April

Medical Economics

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Medical Economics

* * * *April 1949* * * *

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DEPARTMENTS

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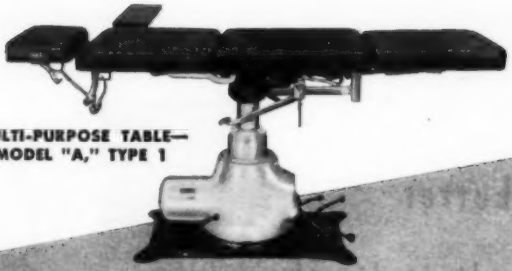
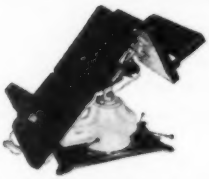


MULTI-PURPOSE TABLE—
MODEL "A," TYPE 1

EXAMINE AND TREAT TO THE *FULL* EXTENT OF YOUR SKILL

with Ritter...
MOTOR-ELEVATED TABLES

Whatever your technique, there's a Ritter Table to lighten your work. Ritter Multi-Purpose Table, Model "A," Type 1, is easily and quickly adjusted for all examination and treatment positions. Air foam rubber cushions. 180° rotation. Can be lowered (27″) so patients of all heights can get on and off the table with ease. Can be raised high enough (45″) to suit your individual technique. Also available with 23″-41″ range. Model "A," Type 2, illustrated left, has adjustable Proctological Knee Rest. Elevation 31″-49″. 55° tilt. Examination and Treatment Table, Model "A" illustrated lower left, has "one-piece" top. 23″-41″. Ask your Ritter dealer for a demonstration.

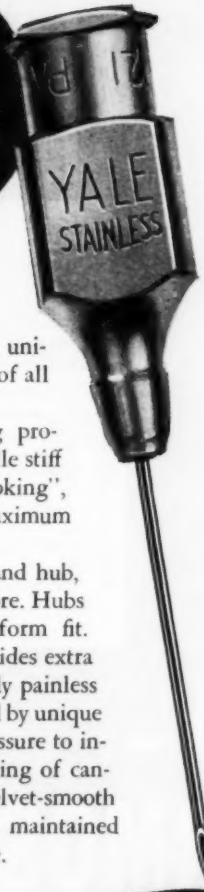


MULTI-PURPOSE TABLE—
MODEL "A," TYPE 2

EXAMINATION and TREATMENT TABLE
MODEL "A"

FOR ADVANCED EQUIPMENT LOOK TO **Ritter**
COMPANY INCORPORATED
RITTER PARK, ROCHESTER 3, N.Y.

Why B-D NEEDLES are always UNIFORM



No matter what the gauge or size, uniformity is an outstanding characteristic of all B-D NEEDLES.

Hyperchrome stainless steel tubing provides the optimal compromise in a needle stiff enough to hold a point without "fish-hooking", and flexible enough to withstand maximum bending without breaking.

From point to junction of cannula and hub, B-D NEEDLES hold practically true bore. Hubs are micrometer-gauged to assure uniform fit. Basic design of B-D needle points provides extra lateral cutting edges to achieve relatively painless penetration. Cannula and hub are joined by unique application of parallel longitudinal pressure to insure against leakage and against crimping of cannula. Buffing and finishing produce a velvet-smooth surface . . . and inspection is rigidly maintained throughout every phase of manufacture.

Write Dept. 21-D for illustrated B-D Needle Standardization Chart

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B-D PRODUCTS
Made for the Profession
Since 1897

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YOUR ARTHRITIC OR RHEUMATIC PATIENT

USED BY PHYSICIANS FOR 14 YEARS*

Ray-Formosil for intramuscular injection is a clinically proved, effective treatment for Arthritis and Rheumatism. It is a non-toxic, sterile, buffered solution containing in each cc.

FORMIC ACID	5 mg.
HYDRATED SILICIC ACID	2.25 mg.

Literature sent upon request.

Supply:	1 cc.	2 cc.
	25—$6.25	25—$7.50
	100—20.00	100—25.00

(These net prices to physicians are 25% off regular list prices)

*C.F.F., M.D., OF PA., HAS REORDERED RAY-FORMOSIL 142 TIMES

RAY-FORMOSIL AMPULS

RAYMER

PHARMACAL COMPANY
PHILADELPHIA 34, PA.
PHARMACEUTICAL MANUFACTURERS

Over a Quarter Century Serving Physicians

Memo from the Publisher

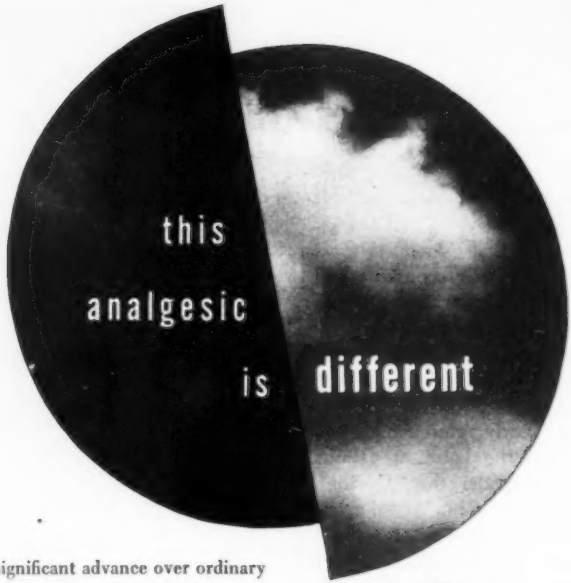
• The average reader of MEDICAL ECONOMICS, in case you've ever wondered, is a 45-year-old private physician who practices in a town of 100,000. He has a wife and two children, whom he supports on a net income of $9,884 a year. To earn this sum, he sees twenty-five patients a day and works sixty hours a week.

For ready reference, we've gotten into the habit of calling this average reader the "Doctor from Peoria." All in all, we know quite a bit about him. For example:

He's been in active practice for seventeen years and doesn't figure to retire for another twenty. He donates 10 per cent of his working hours to charity cases and another 12 per cent to patients who won't ever get around to paying his bill. He spends the equivalent of thirty-three days a year reading medical literature, attending medical conventions, or taking formal post-graduate courses.

We even know what this doctor looks like. He is five feet nine inches tall, weighs 158 pounds, and wears glasses.

There's one additional fact about this man that we have constantly to remind ourselves of: He doesn't exist. There is no "average reader" of this magazine or of any other. And that's what often makes pub-



Edrisal is a significant advance over ordinary analgesics—*it is the only analgesic containing Benzedrine* Sulfate, the rational anti-depressant.*

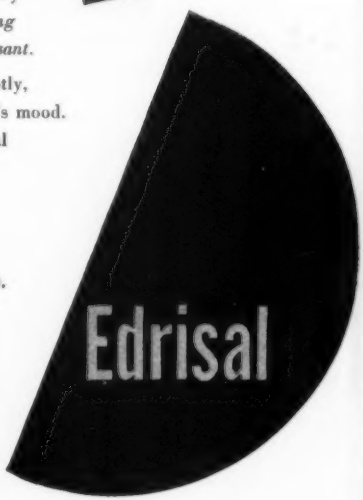
Thus Edrisal, besides relieving pain promptly, also brightens your pain-depressed patient's mood. No wonder so many physicians find Edrisal highly effective in a wide range of conditions characterized by pain, *and by the depression that almost always accompanies pain.*

Each Edrisal tablet contains acetylsalicylic acid (2.5 gr.), phenacetin (2.5 gr.), and 'Benzedrine' Sulfate (2.5 mg.)

For samples and full information, write us at 1536 Spring Garden St., Philadelphia 1, Pa.

*T.M. Reg. U.S. Pat. Off. for racemic amphetamine sulfate, S.K.F.

Smith, Kline & French Laboratories, Philadelphia



its dual action relieves pain, lifts mood

lishing an exercise in divination.

Physicians are, of course, a remarkably homogeneous group education-wise. Some people assume that they're alike in most other respects, too. It just isn't so. Consider some of the extreme types whose readership we want: men earning $500 a year and men earning $100,000 a year; doctors in hamlets and doctors in metropolises; men active in mining medicine and hotel practice, hospital staff work and rural circuit-riding. What's "average" about these men?

All of which means that a number of M.E. articles must be geared to specific groups, not to the hypothetical average. The Peoria practitioner can probably be counted on to read the "typical" M.E. piece—something like "What the New Administration Means to Medicine." But he may skip past occasional items like "A Patent for Your Medical Invention." Still, if minority groups of readers want the information badly enough, such articles are worth running.

The job of gauging what readers want is made considerably easier by the many doctors who tell us about their problems. MEDICAL ECONOMICS tries to be a clearinghouse of practical, interesting information for the M.D. It can be effective only when those who take from it also give to it. We may never hear from that "Doctor in Peoria," but we owe a lot to the real-life readers who qualify as Grade A givers.—LANSING CHAPMAN

advantageous in arthritis

ARTHROKINESIS

Improved mobility of non-ankylosed arthritic joints

Critical analysis shows that over 80 per cent of patients receiving

ERTRON *Steroid Complex, Whittier*

show significant improvement. Ertron's distinctive components, properties and a
—derived from electrical activation of heat-vaporized ergosterol—foster di
tion of soft tissue swelling, improved muscle tone, abolition of pain and enha
well-being, as well as alleviation of muscle and joint stiffness.

Available for oral and parenteral therapy: each Ertron® capsule contains activation-products having 50,000 U.S.P. units, and each ampul 500,000 U.S.P. units of antirachitic activity, biologically standardized.

ARTHRALGEN

Arthralgesic Unguent for quick relief of joint and muscle pain

An effective local measure in rheumatic and allied disorders, Arthralgen™ is rapidly absorbed through the skin. Its speedy analgetic—vasodilator action produces a comforting sensation of deep warmth and relaxation lasting several hours. It is especially beneficial in the interval between initiation of systemic therapy with Ertron and the appearance of Ertron's full anti-arthritic effect. Containing no histamine, Arthralgen does not cause itching or wheals and does not provoke a profound drop in blood pressure.

ARTHRALGEN *Arthralgesic Unguent*

contains 0.25% methacholine chloride, 1% thymol, 10% menthol and 15% methyl salicylate in a super-absorbable, washable ointment base.
Supplied in 1-ounce collapsible tubes.

ARTHROMETER

For evaluation of arthrokinetic effect

The Whittier Arthrometer is a useful device for accurate measurement of improved joint function. It facilitates management of the chronic arthritic by providing an objective record of joint function.

If you have not yet received your Whittier Arthrometer, the Medical Department, Whittier Laboratories will send you one upon request.

Whittier
LABORATORIES
DIVISION NUTRITION RESEARCH LABORATORIES
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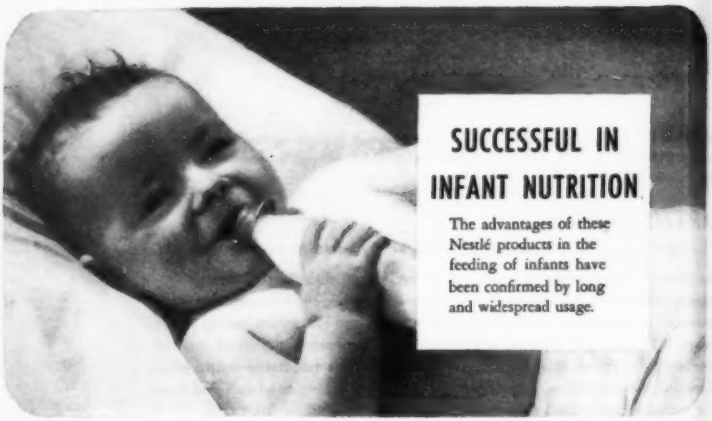

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The advantages of these Nestlé products in the feeding of infants have been confirmed by long and widespread usage.

SPRAY DRIED

LACTOGEN

HOMOGENIZED
WHOLE COW'S MILK

Modified with
MILK FAT
LACTOSE

Reinforced with **IRON**

EVAPORATED

DEXTROGEN

HOMOGENIZED
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DEXTRINS · MALTOSE
DEXTROSE

Reinforced with **IRON**

ACIDIFIED • SPRAY DRIED

PELARGON

HOMOGENIZED
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Reinforced with { IRON, VITAMINS A B C & D }

Requests for literature on any of these products will be given prompt attention.

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155 East 44th Street, New York 17, N. Y.

When there is a strain on nutrition . . .

The demands of pregnancy often lead to impairment of the liver and B-vitamin depletion; it often happens that neither condition will be improved unless they are treated simultaneously.

Methionine is being used widely for protection against impaired liver function. "In the treatment of toxemia and hemolytic disease of the newborn, it is a valuable adjunct to other proved types of therapy. The hepatorenal syndrome can best be treated with the combined use of plasma, whole blood, and methionine."*

The administration of therapeutic amounts of essential B-vitamins has been established as a necessary factor when there is a strain on nutrition.

Meovite Gives This Protection

A new Wyeth product, Meovite, in the form of easy-to-swallow capsules combines the virtues of essential B-vitamins with dl-methionine, one of the amino acids requisite to normal liver function. Four capsules of Meovite daily is the usual dose recommended for pregnant patients; the dosage may be adjusted for special conditions or treatment.

Each Meovite capsule contains 250 mg. dl-methionine, 5 mg. thiamine hydrochloride, 2.5 mg. riboflavin, 25 mg. niacinamide.

Wyeth ®

MEOVITE
TRADEMARK

dl-methionine with B-Complex Vitamins

* Philpott, N. W., Hendelman, M., and Primrose, T.: Methionine in Obstetrics, Am. Jr. Obst. & Gynec. 57:125-142 Jan. 1949

MUCILOSE FLAKES CONCENTRATED
PROVIDE GREATER BULK WITH
SMALLER DOSAGE AT LESS COST
FOR THE TREATMENT OF CONSTIPATION.

MUCILOSE®

for physiologic laxation

MUCILOSE FLAKES CONCENTRATED
MUCILOSE FLAKES WITH DEXTROSE (special formula)
MUCILOSE GRANULES WITH DEXTROSE (special formula)

Dose: 1 or 2 teaspoonfuls with 2 glasses of water twice daily.

Obtainable in 4 ounce and 16 ounce containers.

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WINTHROP-STEARNS

MUCILOSE TRADEMARK REG. U. S. & CANADA

Panorama

Among M.D.'s who died in 1948 were fifty-two Mayors, thirty city councilmen, twenty-three legislators . . . New color movie on cancer diagnosis being circulated among medical schools and county societies; American Cancer Society produced it because "family doctors aren't spotting cancer cases early enough."

Latest Oscar Ewingism: "Forty countries have compulsory health insurance today. In thirty-nine of them, the medical profession first resisted it, later became its most enthusiastic advocate" . . . Minnesota physicians paying expenses of touring clubwoman-lecturer who talks on free enterprise and medicine; they figure her remarks impress some people more than a doctor's would.

Red Cross national blood program in its first year supplied 110,000 pints of whole blood to 700 hospitals, thirty-three clinics; program, says President Basil O'Connor, "still has a long way to go" . . . "World mecca" for post-graduate medical study planned at New York University-Bellevue Medical Center; such is goal specified in $8 million Kress Foundation grant. . . When his patient paid before he billed her, Dr. Hans Tauber of New York became suspicious and hurried to her apartment; he found her unconscious from overdose of sleeping pills, rushed her to hospital in nick of time.

New plastic mattress gently massages bedridden patient when motor pumps air in and out of tiny transverse tubes; device is said to prevent bedsores. . . Conflict between hospitals and anesthesiologists should be adjudicated by "pru-

New Research in Motion Sickness...

"Operation Seasickness"—a rough weather study conducted on U. S. Army Transport *General Ballou*—reveals new chemical compound Dramamine to be a powerful and nontoxic drug in the prevention and control of motion sickness.

Dramamine

A NEW PRODUCT OF SEARLE RESEARCH

—is a distinct chemical entity—β-dimethylaminoethyl benzohydryl ether 8-chlorotheophyllinate.

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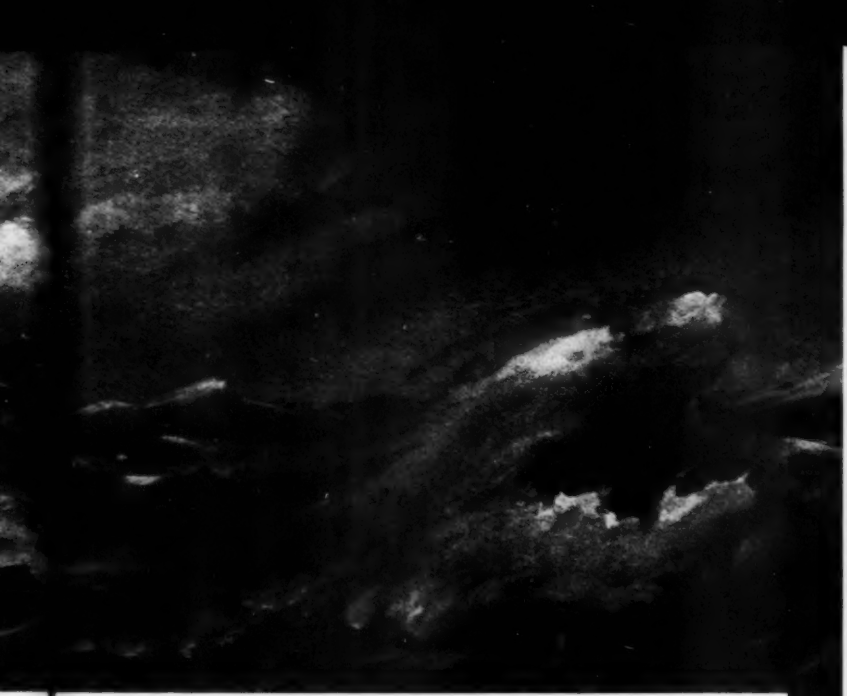


A recent controlled investigation of Dramamine by Gay and Carliner*, of the Allergy Clinic of the Medical Department of Johns Hopkins University and Hospital, conducted aboard a U. S. Army Transport in a rough mid-winter Atlantic crossing, revealed these facts:

1. ***PROPHYLACTIC TRIAL.*** Dramamine *prevented* motion sickness in 98.6% (29% of the placebo-treated controls became seasick).

2. ***THERAPEUTIC TRIAL.*** Dramamine quickly *relieved* 97.5% of established cases of seasickness.

3. ***TOXICITY TRIAL.*** Dramamine produced no undesirable side actions or signs of toxicity.

Dramamine is now available in 100 mg. scored tablets. Recommended dosage is 50 to 100 mg. 4 times daily depending on severity of motion. Literature available on request to

G. D. SEARLE & CO.

Chicago 80, Illinois

*Gay, L. N., and Carliner, P. E.: The Prevention and Treatment of Motion Sickness: I. Seasickness, Bull. Johns Hopkins Hospital, in press.

Clinical tests prove that PRO-CAP is less irritating

"141 patients, including the 130 developing adhesive irritations of various degrees, were then exposed to the adhesive tape containing the fatty acid salts. The plaster was used 970 times on these patients. Only 5 patients developed irritations which were sufficient to cause complaint. The irritation even in those instances was not sufficient to warrant discontinuation of the use of this new plaster."

—R. E. Humphries: New Factors in Adhesive Formulas Which Lessen Irritation. J. Investigative Derm. 9:219-220 (Nov.) 1947

SEAMLESS PRO-CAP ADHESIVE PLASTER

SOLD THROUGH SURGICAL AND HOSPITAL SUPPLY DEALERS

THE ONLY ADHESIVE CONTAINING FATTY ACID SALTS

Seamless PRO-CAP is a superior quality Adhesive Plaster containing zinc propionate and zinc caprylate—two medically-proved ingredients. PRO-CAP provides these *three* important advantages, *at no increase in price!*

- **Skin irritation and itching are substantially eliminated.**
- **PRO-CAP adheres better. Less slime and maceration to interfere with tackiness.**
- **PRO-CAP can be left on the skin or renewed over longer periods, with little or no skin reaction.**

RESULT: More comfort for your patient . . . Less interference with your treatment . . . We invite you to discover PRO-CAP's outstanding qualities in your own practice. Write for illustrated brochure and reprints of medical reports.

FINEST QUALITY SINCE 1877

SURGICAL DRESSINGS DIVISION

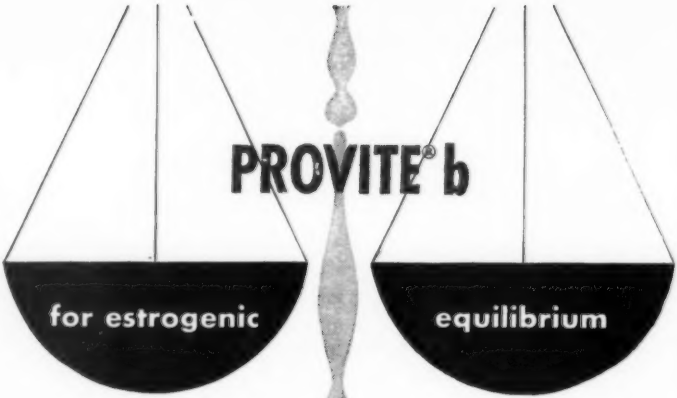
THE SEAMLESS RUBBER COMPANY

dential committee" established by medical staff of each institution, advises Dr. James Raglan Miller, AMA trustee. . . Firm that markets replicas of fine sculptural pieces reports, in some wonder, that 10 per cent of orders come from doctors . . . Since "preservation of peace is the greatest problem of preventive medicine," AMA should endorse world government, asserts Dr. Edward Bortz, AMA past president and member of United World Federalists . . . Video sets are provided for private-room patients by New Rochelle Hospital, N.Y., at charge of $2 a day.

Governor Dewey preparing to build new medical schools in New York rather than help finance expansion of existing ones . . . Drug and surgical manufacturers rallying to support of National Society for Medical Research, formed by such educators as Drs. Anton J. Carlson and Andrew C. Ivy to combat propaganda of antivivisectionists . . . Chiropractors steaming because Selective Service won't defer their students along with those studying medicine, dentistry, osteopathy, and veterinary medicine.

Thirty-nine doctors contributed an average of $4,499 each to $1½ million building-enlargement fund of Memorial Hospital, Danville, Va. . . Medical students, who once sold blood to get pocket money, now pick up occasional fees as donors in artificial insemination, reports Detroit Medical News . . . Newly formed International Academy of Proctology has its headquarters in Flushing, N.Y. . . . Let the individual states act as "forty-eight laboratories" in solving medico-economic problems, advises Senator H. Alexander Smith (R., N.J.), who thinks turning to Federal medicine would be a "premature admission of defeat."

Dr. Laurie Moxham, of Australia, has taken to painting his golf balls with citronella; stuff drives off crows, which had been swiping as many as twenty balls per eighteen-hole round . . . French astrologers have formed a cooperative association to "protect members against charlatans" . . . The journal California Medicine recently ran four-color illustrated spread with scientific article; it cost doctor-author $400.



Failure of the liver to inactivate estrogens leaves excessive amounts circulating in the blood.

With administration of the vitamin B complex in high dosage, as provided in **PROVITE b** Capsules, the liver regains its normal function of metabolizing estrogens, proper balance is achieved, and the condition is corrected.

Typical symptoms of hyperestrogenism are . . . . . .

- hyperplasia of the endometrium
- cystic mastitis
- abnormal uterine bleeding
- premenstrual tension
- amenorrhea

To restore estrogenic equilibrium, prescribe **PROVITE b** Capsules. Each capsule contains. . . . . .

Thiamine HCl	25.0 mg.
Riboflavin	12.5 mg.
Pyridoxine HCl	1.5 mg.
Niacinamide	150.0 mg.
Choline Dihydrogen Citrate	100.0 mg.
Inositol	50.0 mg.
d-Calcium Pantothenate	5.0 mg.
Secondary Liver Fraction	q. s.
Dried Yeast	q. s.

Write to Medical Department for additional information and samples.

IVC®

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TURN Jeers TO CHEERS!

FOR MILK!

The extraordinary nutritional importance of milk in the dietary during infancy, childhood, pregnancy and old age — and for many gastro-intestinal and pre- and postoperative conditions — need not be lost to patients who are unable (because of personal dislike) to ingest it. Jeers for milk may be turned into cheers through the simple admixture of "Junket" Rennet Powder or Tablets. They transform milk into highly acceptable, deliciously flavored rennet desserts, which are eye-appealing and taste-tempting to young and old alike. These uncooked, custard-smooth rennet desserts in no way change the nutritional factors of milk, but they do facilitate easier, more rapid digestion because of the softer, finer, more flocculent curds produced in the stomach by the enzymic action of rennin.

Send For Authoritative Personalized Children's Diet Lists

Your name, address and telephone number imprinted on authoritative comprehensive diet lists for "Younger Infant," "Older Infant" and "Toddlers," are offered as a complimentary service by "Junket" Brand Foods. Fill out and mail coupon below for sample lists.

"JUNKET" BRAND FOODS

Make Rennet-Desserts with either:

"JUNKET" BRAND RENNET POWDER —already sweetened; six popular flavors.

"JUNKET" BRAND RENNET TABLETS —unsweetened, unflavored (particularly for diabetics).

"JUNKET" is the trade-mark of Chr. Hansen's Laboratory, Inc. for its rennet and other food products, and is registered in the United States and Canada.

"JUNKET" BRAND FOODS
Division of Chr. Hansen's Laboratory, Inc.
Little Falls, N. Y.

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Please send samples of diet lists and trial packages of "Junket" Rennet Powder and Tablets.

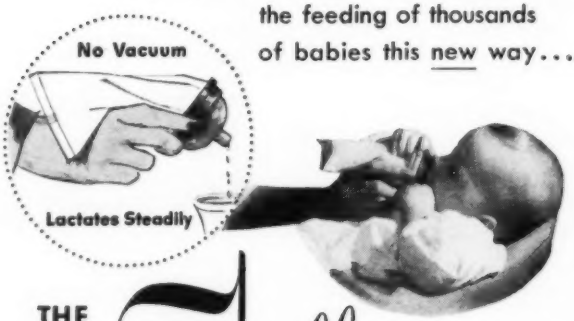
Name_____
Please Print

Address_____

City_____ State_____

"The nearest approach to breast feeding"

say doctors and nurses who have supervised the feeding of thousands of babies this new way...



THE Shellie NURSER

with pre-sterilized disposable bottles and nature-soft Natural-Action Nipples

Shellie Disposa-Bottles of flexible plastic "Shellene" collapse as the formula is withdrawn . . . no vacuum can form to cause air colic. Natural-Action Nipple of pure gum rubber copies the human breast . . . broad, soft, areola-like base can't collapse, gives maximum sucking exercise. Easy to fill . . . 24 hour feedings can be prepared in less than 10 minutes.

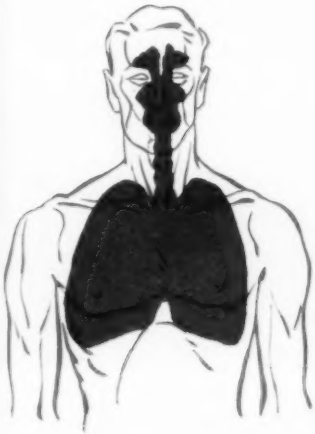
SHELLIE NURSER SET — *3 complete nurser units, bottle expander, assembly rack, roll of 250 sterile, disposable nipple protectors.* **$3.75**

SHELLIE NURSER KIT — *6 complete nurser units, bottle expander, 2 assembly racks, 250 sterile, disposable nipple protectors.* **$6.95**

SHELLIE DISPOSA-BOTTLES — *Pre-sterilized, in rolls of 100—4 oz. or 65—8 oz. size.* **$1.00**

SHELLMAR PRODUCTS CORPORATION • MT. VERNON, OHIO

NEW!



PYRIBENZAMINE EXPECTORANT

for relief of cough
and other
respiratory symptoms...

PYRIBENZAMINE EXPECTORANT is a unique combination of non-narcotic drugs, highly effective for the relief of coughs and other respiratory symptoms.

Each teaspoonful of Pyribenzamine Expectorant contains 30 mg. of Pyribenzamine citrate, 10 mg. of ephedrine sulphate and 80 mg. of ammonium chloride.

Pyribenzamine has been shown to block the congestive action and the spasmogenic effect of histamine. In addition it depresses the cough reflex and the sensitivity of the pharyngeal mucosa.

Pyribenzamine and ephedrine act synergistically to promote decongestion of the entire respiratory tract, including the nasopharyngeal mucosa, so frequently involved in allergic and associated infectious respiratory disease.

DOSAGE—ADULTS: 1 or 2 teaspoonfuls every 3 to 4 hours followed by a small glass of water.

CHILDREN: ½ to 1 teaspoonful every 3 to 4 hours.

- Pyribenzamine Expectorant is issued in bottles of 1 pint and 1 gallon.

Ciba PHARMACEUTICAL PRODUCTS, INC., SUMMIT, NEW JERSEY

PYRIBENZAMINE (brand of tripelennamine)—Trade Mark Reg. U.S. Pat. Off. 2/1489M

for a Healthier, Happier Old Age . . .

the pleasant-tasting nutrient

AMINO-CONCEMIN®

A SYNERGISTIC COMBINATION OF B COMPLEX, IRON AND AMINO ACIDS

Geriatric care is frequently complicated by diminished reserves, poor appetites and inadequate diets.

AMINO-CONCEMIN overcomes these deficiencies and augments the elderly patient's lowered recuperative powers with a rationally balanced formula containing:

1 **B COMPLEX**—the established B vitamins in high potencies, plus the entire B complex from three natural sources.

2 **IRON**—in a well-tolerated, readily available form to aid in counteracting the frequently associated hypochromic anemias; and

3 **AMINO ACIDS**—supplemental amounts for *extra* nitrogen as well as a synergistic effect on hemoglobin formation and vitamin assimilation.[1,2] "The utilization of vitamins by the organism . . . seems to be defective unless adequate amounts of amino acids of the proper type are available."[3]

rich winey flavor important

"Taste" is an important therapeutic ingredient in geriatric therapy. The unique *rich winey flavor* of Amino-Concemin not only masks the unpleasant taste of liver, iron and amino acids, but encourages continued ingestion, as well. Blends with milk or fruit juice. Average dosage: 1 tablespoonful (15 cc.) three times a day, with or before meals.

TO SPEED CONVALESCENCE—AMINO-CONCEMIN

1. Jacobson, M.: N. Y. State J. Med. **45**:2079-2080 (1945).
2. Ruskin, S. L.: Am. J. Dig. Dis. **13**:110-122 (1946).
3. J. A. M. A. **22**:386 (1948).

THE WM. S. MERRELL COMPANY • CINCINNATI, U. S. A.

MERRELL 1828

Speaking Frankly

Interneships

A prime reason for the G.P. shortage is that young doctors who would like to do general practice cannot get adequate training for it. I don't know of a single teaching hospital where a real rotating interneship can be obtained. Men looking for training of this type have to interne in a non-teaching institution—which often means a substandard hospital. Rather than risk the stigma of second-rate training, the better students inevitably decide to specialize.

Amos C. Gipson, M.D.
Gadsden, Ala.

Psychoquacks

I wonder how many physicians saw Dr. Fishbein's article on psychiatric quackery in the Woman's Home Companion for December. Dr. Fishbein complains that psychologists are practicing medicine in the psychiatric field, then proceeds to stump for psychological state licensing as a means of prevention.

All the charlatans will organize behind him, because they have been looking for any kind of licensing that will bless their medical racketeering. Bringing the medical practice statutes up to date to cover psychiatry is a solution Dr. Fishbein completely overlooked.

Sam Parker, M.D.
Director of Psychiatry
Kings County Hospital
Brooklyn, N.Y.

Assessment

Your article on the AMA levy refers to its voluntary aspects. The levy was enacted by the House of Delegates as an assessment, not as a contribution. At its June meeting, the house may take strong action if any large number of county societies or individual members refuse to pay.

M.D., New Jersey

The AMA assessment is unfair because it makes no allowance for the young doctor who is just starting out in practice. His assessment is the same as that paid by a $100,000-a-year colleague. I propose that contributions be exacted on the basis of yearly gross income.

A. D. Jonas, M.D.
New York, N.Y.

No union, not even that of John L. Lewis, rules its members with more of an iron hand than does the American Medical Association. As a fellow of the AMA, I consider

the assessment an undemocratic act of brazen boldness.

As an alternative to the levy on individual doctors, I suggest that the large medical commercial houses contribute the requested total sum.

M.D., New Jersey

Oldsters

I enjoy your comments and criticisms, but I don't go along with your remarks about the "old fellows" in the AMA House of Delegates. Much of the work on reference committees and at hearings is done by these men. I fully agree that the younger group should participate, but they are apt to regard the annual meeting as a sort of vacation. It takes time for a delegate to become instilled with his duties and to become a participant.

George W. Kosmak, M.D.
New York, N.Y.

Certification

Up until 1947, the Board of Dermatology admitted two types of candidate to its exams: those with three years of formal training and those who had practiced dermatology for at least ten years. Since 1947, the latter group has been barred from the exam. This shuts the door on a lot of competent men who have done pioneer work in their communities.

Is it the function of the American Boards to weed out candidates for certification on an arbitrary and dictatorial basis? It would appear so. I suggest that the medical so-

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cieties look into the question of modification and control.

M.D., Massachusetts

Postmarks

That quiz in your December issue caused me to dip into my own collection of postmarks with a medical slant. Here are a few more for your list:

Ether, N.C.
Backbone, Ky.
Bone Gap, Ill.
Plasterburg, Va.
Catarrh, S.C.
Trussville, Ala.
Pill, England
Mumps, England

Howard K. Thompson, M.D.
Boston, Mass.

Here's one you overlooked in your collection of postmarks: Intercourse, Pa.!

M.D., Michigan

Blood

In connection with your February article on blood banks, you may be interested in the following points on the work of the AMA liaison committee:

¶ The committee has been directed by the AMA House of Delegates to conduct a study of private blood banks throughout the country.

¶ The committee will cooperate with the American Association of Blood Banks to safeguard the interests of private banks.

¶ At a February meeting with the Red Cross in Washington, the com-

mittee took up ways and means of settling local controversies and of avoiding them in the future.

L. W. Larson, M.D.
Chairman, AMA Liaison Committee
Bismarck, N.D.

I think the Red Cross could do a fine job if it would furnish funds and equipment but allow local physicians to handle the actual establishment of the banks. Without a war, civilians are not going to give their blood to a national, semi-governmental organization with the same enthusiasm they'd display in contributing it to a local community project.

Robertson Ward, M.D.
San Francisco, Calif.

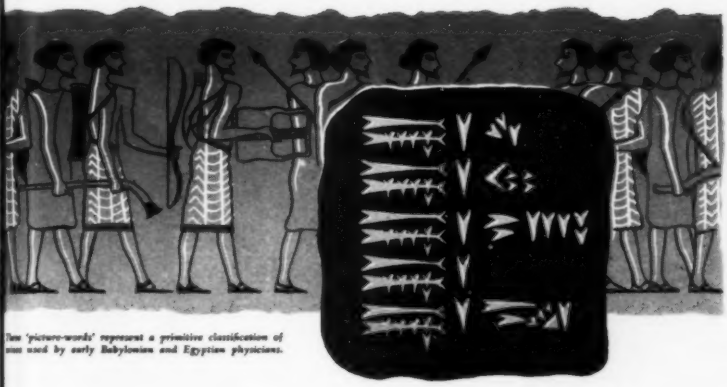
Deafness

That article, "When the Patient Asks About Deafness," makes the problem seem much simpler than it is.

Most of the fifty-five hearing clinics scattered around the country are years behind the times. Even among the otologists, few know much about hearing aids. I know many fine ear men who say to their patients: "Here's a list of ten firms. Go downtown and pick out the hearing aid that suits you best."

To help alleviate this situation, I am trying to establish an Institute for the Hard of Hearing. Here, under one roof, will be gathered all the latest aids for testing, prescribing, and training in lip reading.

Henry A. Brodkin, M.D.
Newark, N.J.



These 'picture-words' represent a primitive classification of urine used by early Babylonian and Egyptian physicians.

centuries to perfect seconds to perform

When Sumerian and Babylonian physicians, *circa* 4000 B.C., noted the varying colors and constitutions of the "water of the phallus," they were probably not the first uroscopists in history. They were assuredly not the last, for fifty-odd centuries were to elapse before Fehling's first paper on the copper reduction test for urine-sugar appeared in 1848.

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REFERENCES: 1. Rosenblum, H. and Fraser, L. E.: Proc. Soc. Exper. Biol. Med., 65:178, 1947. 2. Dry T. J. et al.: Proc. Staff Meetings, Mayo Clinic, 21:497, 1946. 3. Beliele, M.: Union Med. Can., 77:592, 1948.

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*Citrus fruits—among the richest known sources of Vitamin C—also contain vitamins A, B, and P, readily assimilable natural fruit sugars, and other factors such as iron, calcium, citrates and citric acid.

References:

1. Gordon, E. S.: Nutritional and Vitamin Therapy in General Practice, Year Book Pub., 3rd ed., 1947.
2. Manchester, T. C.: Food Research, 7:204, 1942.
3. McLester, J. S.: Nutrition and Diet, Saunders, 4th ed., 1944.
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FLORIDA

Oranges • Grapefruit • Tangerines

Sidelights

Red Menace

Do Communists have any influence in medical circles? Are they pulling the strings in the current campaign for nationalized medicine?

Some months ago, this magazine assigned a competent, free-lance investigator to learn the facts. He found, of course, that Communists everywhere supported the principle embodied in the Wagner health bill. But nowhere, in the course of his check-up, did he find them a force to be reckoned with. And nothing we've been able to uncover since then controverts his finding.

The sooner the Red label is dropped from medicine's armamentarium, the better. Compulsory health insurance is now an American issue. It will have to be resolved as such.

Short End

Fee-splitting may be defined as an unethical way to resolve the fantastic discrepancies between general and specialized practice.

Take this familiar case: A G.P. is called at three in the morning to see a boy with a bellyache. After sweating it out with the family, he sends the boy to the hospital. There the surgeon operates almost at leisure. The G.P.'s fee may be $5, the surgeon's $150.

No one tries to justify the inequity of the situation. The fact that fee-splitting is the unethical solution shouldn't deter us from looking for better ways of assuring the G.P. a fair return.

Bring In the Public

It seems painfully clear that organized medicine will never gain wide public support as long as it insists that it be recognized as sole arbiter of what is best for the public. Yet take a look at the latest Blue Shield reports: They show that some dozen of our medical-society-sponsored prepay plans still have no laymen on their governing boards.

An important segment of the people finds this arrangement unreasonable. Being vitally affected by the distribution of medical care, it feels it is entitled to some say in the matter. If we don't cheerfully concede this point, the public will sooner or later take matters into its own hands.

Actually, a partnership with the public offers us our best hope for the future. If the public is allowed to share in the organization of our

prepayment plans, it will defend these plans to the last ditch.

This is no news to most Blue Shield men. The average plan's governing board, in fact, comprises ten physicians and five laymen. While still more can be done to bring that ratio more nearly into balance, the immediate need seems to be for a little enlightenment among the plans that now include *no* lay representation.

Union Strategy

A few of our leading industrialists have clasped the compulsory health insurance idea to their bosoms. To their way of thinking, the scheme is the lesser of two evils. Under a Wagner plan, they'd expect to pay out perhaps 2 per cent of payroll for a Government-operated health program. Without a Wagner plan, they fear they'll have to pay higher sums for a union-operated program.

What these men may overlook is the union viewpoint. Last month one top union officer told this magazine: "The idea of national health insurance is fine, and we're all for it. But this program will provide only for minimum health needs. It will require augmentation through collective bargaining."

Realistic businessmen are well aware of these sentiments. They are weighing compulsory health insurance on its own merits and demerits—not as an alternative to something else.

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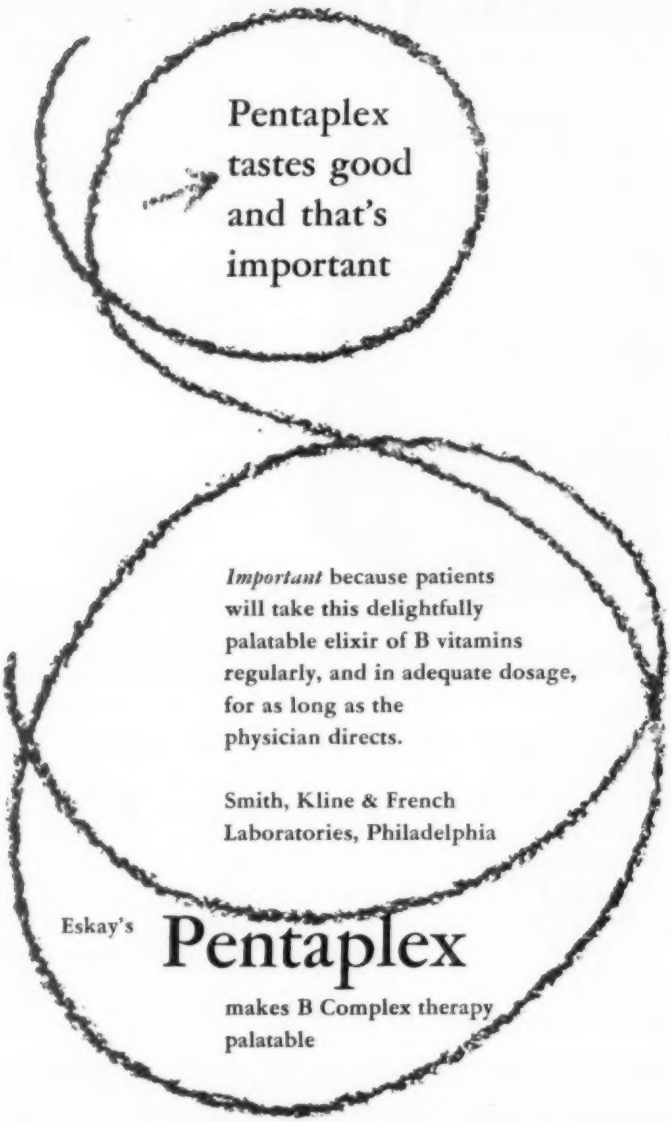
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Editorial

The Middle Road

• The most striking new development on the health legislation front is the search for a middle ground between voluntary and compulsory insurance. No one has yet suggested how, without some government aid, voluntary health insurance can be extended to those unable to pay the premiums. On the other hand, millions of thoughtful citizens still recoil from the idea of inflicting Federal medicine on everyone.

What, then, is the answer?

Many of us are beginning to see it as a part-voluntary, part-compulsory system of health insurance. The men who favor this approach range from Senator Robert Taft (R., Ohio) to Senator Lister Hill (D., Ala.), from Bernard M. Baruch to the AMA Board of Trustees. What still has to be worked out is the mechanics of the scheme.

Here's the sort of thing we have in mind:

Our chief need is for Federal grants-in-aid to the states, earmarked for one specific use: to pay the health insurance premiums in voluntary, nonprofit plans for those people who can't afford them. This would, in effect, provide tax-financed health insurance for the lowest quarter or third of the population. Yet it would do this without scrapping the voluntary plans, which already cover a sizable segment of the American people.

Each state should determine for itself which people to subsidize. As Dr. Thomas Parran points out, this job is sometimes difficult but never impossible. In these days of payroll deductions, the amount of a person's income is easily ascertainable. It is checked routinely, without stigmatizing the person concerned, in income tax procedure, in public housing projects, and in many hospitals and medical offices. A simple, confidential report form could serve the purpose of the much-maligned "means test."

Under this plan, one state might choose to assist all those whose annual incomes were less than $2,000. Another might aid those whose medical-hospital expenses (including insurance premiums) topped 10 per cent of their annual incomes. The questions of full or fractional subsidy, of how to allow for dependents, would be settled according to each state's views. Out of the cumulative experience might well come a sound, tested pattern for

prepaid health insurance.

Let's recognize that the proposed insurance system would need some supplementing. The voluntary plans do not yet cover *all* costs of illness (nor has any compulsory plan yet proposed). So it's clear that part of the Federal subsidy would have to be used to pay medical-hospital bills that people eligible for help can't insure against. (As the plans broadened their coverage, and as they developed actuarially sound premiums for poor risks, the need for this direct-assistance fund would diminish.)

Some doctors, of course, balk at the idea of *any* form of tax-financed health insurance. Let these men ponder the verdict that Professor Walter Sulzbach arrived at after years of studying the German system: "It is not compulsory health insurance as such that affects the medical profession . . . but the percentage of the population it covers. When the number of the insured is less than, say, a third to one-half the population, and the people who are better off, including the lower middle class, are not covered, there is no reason why the doctors should be dissatisfied."

A part-voluntary, part-compulsory health insurance plan would supplement rather than supplant private practice. It would shift the burden of indigent medical care from private medicine to society as a whole. It would cost only a fraction of what a Wagner plan would cost; and matching features could serve to keep the states from squandering Federal funds.

Best of all, the plan would make available to all our citizens protection against the economic shock of illness. Yet it would do this without setting up an all-encompassing scheme that could throw our medical care system into turmoil.

Oscar R. Ewing has said, "I hold with the admonition of Lincoln: that it is the business of government to do for the people what they, as individuals, cannot do for themselves." The middle-road approach seems to meet this specification far better than Mr. Ewing's own blueprint for national compulsory health insurance.

—H. SHERIDAN BAKETEL, M.D.

Mother's Helper

• The parents looked on anxiously as I examined their 5-year-old's sore ear. For conversation, I told him I wanted to see if Mother had been "putting bugs" in his ears. Imagine my embarrassment when I looked into the otoscope and saw a large, green bug lying against the ear drum. —C. L. BUSBY, M.D.

What's Going On in Congress

Delays hurt chances of W-M-D measure, set stage for less controversial health bills

• For opponents of compulsory national health insurance, the year's first promising news from Washington is the failure of the Truman legislative machine to pick up speed on schedule. As of mid-March, no major legislation had reached final enactment. Even relatively noncontroversial bills, originally scheduled for speedy passage, faced the threat of Capitol Hill inactivity, delay, or ensnarlment.

On the Senate side, protracted debate on repeal of the Taft-Hartley labor law shoved serious work on the Wagner-Murray-Dingell bill into the background. Both measures, along with a half-dozen other important bills, come within the jurisdiction of the Committee on Labor and Public Welfare. Because the same Senate committee handles virtually all significant health legislation, such projects as the National Science Foundation and aid to local public health units failed to make anticipated progress.

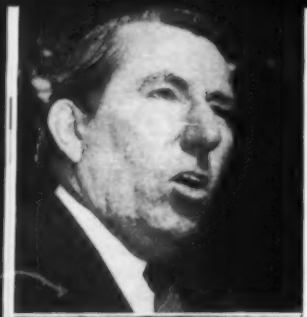
On the House side, the outlook for the Truman program was even worse. Selected to carry the ball on most health bills, the House Committee on Interstate and Foreign Commerce took two months to complete its organization procedure and get down to work. This committee also has jurisdiction over oil, transportation, communications, and a number of other important fields. So it's likely that the Senate will have to set the pace on health insurance.

Target Date

Time is on the side of those who oppose the Wagner-Murray-Dingell program. Every day's delay contributes to the chances of staving off its enactment during 1949 or 1950. If the W-M-D bill is not passed next year, its opponents may be able to make their weight felt in the November 1950 Congressional elections.

Time also is vitally important to

**Wallace Werble, author of this article, has been a Washington newsman for more than fifteen years. Currently he is editor of F-D-C Reports, a weekly newsletter for the drug and related industries.*



Three of the five members of the Senate's subcommittee on health are (top to bottom) Senators Claude Pepper (D., Fla.), Forrest Donnell (R., Mo.), and H. Alexander Smith (R., N.J.). Their report on the Wagner bill will be routed to Sen. Elbert Thomas (D., Utah), bottom, who heads the full Committee on Labor and Public Welfare.

those who are pushing voluntary insurance as the alternative to the Wagner plan.

Already some 55 million people are enrolled in various types of voluntary prepayment. If this enrollment could be pushed above 100 million, coverage would be more widespread than that now promised by advocates of compulsory insurance. In this way, the hard core of support for the W-M-D plan might be dissipated.

For their part, the Truman forces must hold extensive health hearings this session in either the Senate or the House. Last month the Senate Labor Committee's subcommittee on health announced that it hoped to get some hearings under way "within a few weeks."

Meanwhile, the AMA and other groups opposed to national health insurance are planning to make good use of their borrowed time. A stepped-up AMA public relations program can have a significant impact in Washington. Though not too different from previous pronouncements, the AMA twelve-point program released in mid-February left its mark on Capitol

Hill. It gave the moderates something to work with.

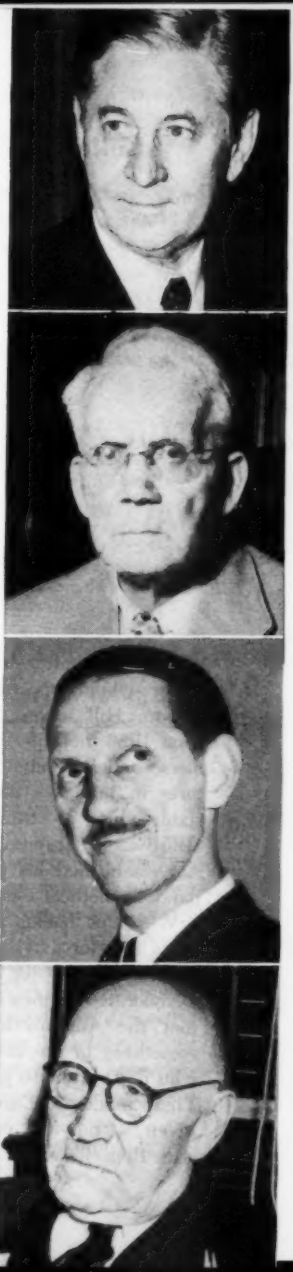
Three points in the AMA program drew particular attention in Washington:

¶ Extension of voluntary plans "as rapidly as possible into rural areas" with "aid through the states to the indigent and medically indigent by the utilization of voluntary hospital and medical care plans, with local administration and local determination of needs."

¶ Establishment in each state of a medical care authority to receive and administer funds, with proper representation of medical and consumer interest.

¶ Provision of facilities for care and rehabilitation of the aged and those with chronic disease.

While the anti-health-insurance forces still have a long road to travel, the chances of forcing the Truman Administration to be content with a compromise program are improving. Of course, the deepest-dyed Wagner-Murray-Dingellites will never give up. But the Administration is faced with so many vigorous controversies—taxes, Atlantic Pact, civil rights, etc.—that



Key roles are played by (top to bottom) Sen. James Murray (D., Mont.), chairman of the Senate health subcommittee; Rep. Robert Crosser (D., Ohio), head of the House Committee on Interstate and Foreign Commerce; Rep. John Dingell (D., Mich.); and Rep. Robert Doughton (D., N.C.), House Ways and Means Committee chairman.

* HANDITIP *

Collection Aid

Here's an idea for small-town practice: I always carry with me checkbooks from both local banks. The checks are already made out in my name. Many patients, I've found, appreciate the convenience of merely filling in the amount and signing.

—M.D., VERMONT

* * * * *

the President may be forced to make some realistic choices between half loaves or nothing.

In this picture, Senator Lister Hill (D., Ala.) may emerge as one of the important figures. The son of a well-known Alabama surgeon, he was named after the great Lister, under whom his father studied. Senator Hill served in the House from 1923 to 1938, is finishing out his second full Senate term (it expires in January 1951). His joint sponsorship of the non-partisan Hill-Burton Hospital Construction Act established his interest in expanding medical care facilities.

With this background, the Alabama Senator may be able to provide leadership for the moderate Democrats—the men who recognize that the Administration must do something in the health fie'd, but who don't want to go all the way. These moderate Democrats can, if given a rallying point, combine with Republicans to prevent enactment of compulsory health insurance.

It is noteworthy that the moderate Democrats were shut out of representation on the health subcommittee of the Senate Labor Committee. Democratic members are Senators James E. Murray (Mont.), chairman; Hubert H. Humphrey (Minn.); and Claude Pepper (Fla.). Had one of these been a moderate, he could have combined with the GOP subcommittee members—Senators Forrest Donnell (Mo.) and H. Alexander Smith (N.J.)—to make the road rougher for the Wagner bill.

Early in the session, Senator Hill conferred at length with Dr. Gilson Colby Engel, president of the Pennsylvania State Medical Society, on a proposed ten-point program outlined by the latter. This program was turned over to the legislative drafting service of the Senate, with instructions to determine whether it could be converted into a formal legislative proposal. While this was going on, the AMA came out with its twelve-point program. It is very similar to the Engel proposals.

Senator Hill's effort to translate these programs into a bill amounts to wrapping up in one package a number of separate measures that probably would be enacted in any event. If passed individually, the bills hardly could be considered a program. When lumped together, they may form the basis of a com-

[*Continued on* 144]

POST-WAR PROJECT of Herman Parris started during terminal leave, resulted in 150 musical works.

COMPOSER

CLOSE UP

Anyone who thinks of a hospital as something prosaic should bend an ear in the direction of Dr. Herman Parris. To him, the nurse is a melody; the interne walks along the corridor with a syncopated beat; and surgery is a scherzo.

Dr. Parris, an ENT man from Philadelphia, has summed up these musical impressions in a symphonic work called "The Hospital Suite." It had its premiere last spring in New York City. Appropriately enough, the renderers were the Doctors Orchestral Society, a fifty-five piece ensemble of physicians who find spare-time relaxation in music.

The critics were delighted. Said

The New York Times' Olin Downes: "Full of lively orchestral effects—not a fumbling measure in it." Commented another: "Dr. Parris is an expert orchestrator. He knows the art of winding and unwinding a sprightly theme."

The suite is a fourteen-minute musical narrative. It relates the experiences of a patient who arrives at the hospital for an operation. In the music Dr. Parris describes the patient's timid approach to the information desk, her encounters with nurse and interne, her pre-operative prayer, and finally the going home. This last episode is set to the tune of a joyful march.

Cues for Listening

The piece even has program notes to go with it, written by the conductor of a Philadelphia orchestra. Excerpts: "The patient chatters nervously at the information desk. In her opinion, an appendectomy is *not* necessary . . .

"The white-robed operating-room personnel look like a fluttering, Monday-morning washline. She clamps her eyes shut, then opens them. The surgeon looks like Boris Karloff . . . "

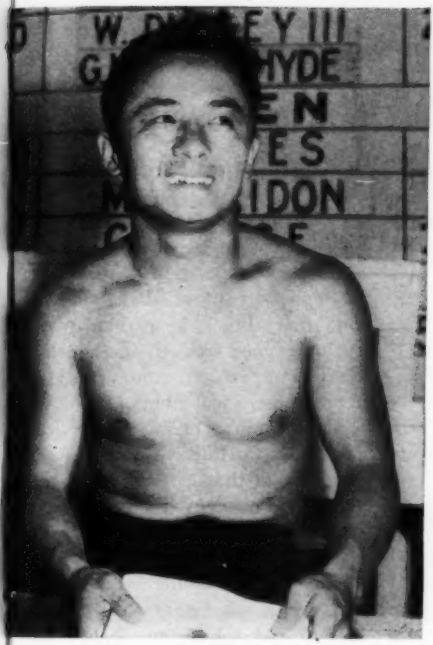
Plump and friendly Herman Parris has always had music on the brain, although he began only recently to write it. While taking premed at the University of Pennsylvania, he enrolled in its School of Music. After only one year's work he received a certificate of proficiency for four years of music training. But medicine soon forced music to the background.

The 45-year-old doctor's musical energies, suppressed since his undergraduate days, burgeoned anew while he was on terminal leave from the Army. "I spent so much time composing," he says, "that my wife began to worry." In three years he dashed off 150 compositions including five piano concertos, a symphony, a bass clarinet suite, an octet for woodwinds, and several popular songs soon to be published. "Most of it had been bottled up in me for years," he explains. "I simply exploded."

Dr. Parris spends most of his spare time—about ten hours a week—working furiously at the baby grand piano in the living room of his small apartment. He works so fast that the manuscript looks more like bird scratchings than music. Each score is turned over to a copyist for more legible reproduction. This is expensive, having already cost him hundreds of dollars.

The composer-physician admits that he enjoys critical plaudits and would like to hear more of his works played. It's not easy, he's found, for an M.D. to attain recognition as a writer of serious music. "Most musical big-shots," he says, "seem to feel that stuff written by a doctor isn't worth looking at."

But this fazes Composer Parris only in passing. "I'd go right on writing music," he says, "if no one ever played a note of it." END



OLYMPIC CHAMPION
Sammy Lee says he didn't get stagefright when 12,000 watched him dive at the 1948 Games. "People look so small from the high board," he says, "you don't think much about them."

AQUABAT

CLOSE UP

Captain Sammy Lee of the U.S. Army Medical Corps is a little man who makes a big splash. Winner of the 1948 Olympic tower-diving championship, Medical Officer Lee makes the slickest two-and-a-half gainers and the best spins to be seen anywhere. The trick of bouncing off a platform thirty-three feet high, he says, is as easy as stepping from a curb. It's simply a matter of touch and control.

By winning the world's top diving honor, the 28-year-old Lee realized the second of his two chief ambitions. The first—to become a doctor—was achieved two years ago when he was graduated from the University of Southern California Medical School. After he finishes his present stint with the Army he hopes to start a residency in ENT.

American-born of Korean parents, Captain Lee has been a springboard star ever since high school. "As a kid," he says, "I always liked swinging, jumping, and the sensations generally associated with falling through space. Diving was a natural for me."

For a dozen years now, sports-

writers have been cheering the 138-pound "Oriental from Occidental" (he attended Occidental College in Los Angeles). They whooped when he won the Pacific Coast AAU springboard championship. They moaned when, in 1942, after capturing both the U.S. high-diving and springboard championships, he retired to study medicine. It looked as though U.S. aquatic sports had lost a gifted performer.

For five years he made no competitive appearances. Then, in 1947, while he was stationed at MacCormack General Hospital in Pasadena, an order came relieving him of all medical duties and directing that he "report to the nearest swimming pool." Says Diver Lee: "You should have seen the expression on my C.O.'s face."

Obediently, Sammy Lee began tuning up for the Olympics. He concentrated on a front three-and-a-half somersault, a dive he invented. It won him the championship. "It was my final dive in London," he says. "One judge scored it a perfect ten. Five others gave me 9.5, but the last came up with only seven. He was booed."

His diving career has not been without some spectacular miscues. Once he lit flat on his back and came out of the pool coughing blood. Another time, when the water had been partly drained from the tank, he misjudged his distance, landed on his face, and was knocked out. Even champions aren't immune to belly-busters. END

CROSSROADER

Dr. David Bradley peered at the atomic explosions of Operation Crossroads through a pair of dark glasses. But that didn't keep him from getting a good look at radio-activity on the rampage. What he saw as an Army radiological monitor at Bikini is set down in a chilling book called "No Place to Hide." It was a recent selection of the Book-of-the-Month Club, and condensed versions have appeared in the Reader's Digest and the Atlantic Monthly. A documentary film is in the making.

Despite the book's success, the 34-year-old physician feels that his message needs more personal telling. He's interrupted his surgical residency at the University of California Hospital to tour the country, lecturing fellow citizens on the perils of atomic power. "My training can wait," says lanky, bespectacled Dave Bradley. "I've got to follow up this bomb business. Because if we don't avoid another war, we're all washed up."

The question that lecture audiences ask oftenest is how he got mixed up in the A-bomb project to start with. "I was chosen by card index," he grins, "Army fashion." A graduate of Harvard Medical School, he'd joined the Army in

BIKINI DIARIST David Bradley dedicated book about the A-bomb to his two children, "who will know whether we have made that cloud man's masterpiece or his master."

1945. He was doing rehabilitation work at Colorado Springs when suddenly ordered to Oak Ridge. Five months later he was on his way to Bikini.

He flew in one of the two planes making a post-explosion reconnaissance of the A-bombed lagoon. After that his job was to explore the target areas, armed with a Geiger counter, and to warn other investigators away from spots too hot for safety.

"The toughest job was convincing the men in my detachment that death lurked in a pane of glass or a cake of soap," he says. "But the men feared sterility more than death. All they wanted from me was assurance of continuing manhood. Given that, they'd be willing to tackle an atomic bomb every morning before breakfast."

Separated from the Army in 1947, he started on his book shortly after. Its somber conclusions: (1) There's no defense against the bomb. (2) Its deadly effect lingers on for centuries. END

Medical Care Plans Growing Fast

A progress report on the doctor-sponsored plans, plus an estimate of their future

● The rising tide of voluntary medical care insurance, long derided by advocates of compulsory plans, is beginning to lap about the feet of its detractors.

Blue Shield enrollment last year jumped more than 43 per cent, to 10,200,000. The prediction is for 13 million members by the end of this year, 16 million by the end of 1950. In the light of growth since the war (259 per cent) or since 1942 (1,355 per cent), this seems a conservative estimate.

Seven years ago, physician-sponsored medical care plans encompassed ten states (and only 700,000 people). Today they cover forty-five states, the District of Columbia, and the Territory of Hawaii. Only South Carolina, Georgia, and Maryland are among the missing.

Biggest membership gain last year was scored by New York's United Medical Service. Nearly 400,000 recruits in the first nine months put it well over the million-member mark. Percentagewise, Pennsylvania's Medical Service Association was a star performer. It gained 171 per cent. Total membership in the Keystone State (353,643) is still low in relation to population; but last year's showing illustrates what can happen when local Blue Shield and Blue Cross people decide to bury the hatchet.

Closest to the saturation point, of all Blue Shield plans, is the one in Delaware. Its membership comprises 49 per cent of the state's population. Second place in this category belongs to Michigan Medical Service, with 21 per cent enrolled.

Boost from M.D.'s

Chiefly responsible for Blue Shield membership gains is growing doctor cooperation. Medical care plan payments to physicians totaled some $60 million last year, up 50 per cent from 1947; but this was probably less a cause than an effect of what is described as a "much better" doctor attitude. Blue Shield plans in Michigan, California, Massachusetts, and Ohio have been particularly successful in winning more active backing of M.D.'s.

Doctor cooperation is helping in tangible ways that increase the plans' salability. For instance, take

the developing trend from indemnity to service contracts:

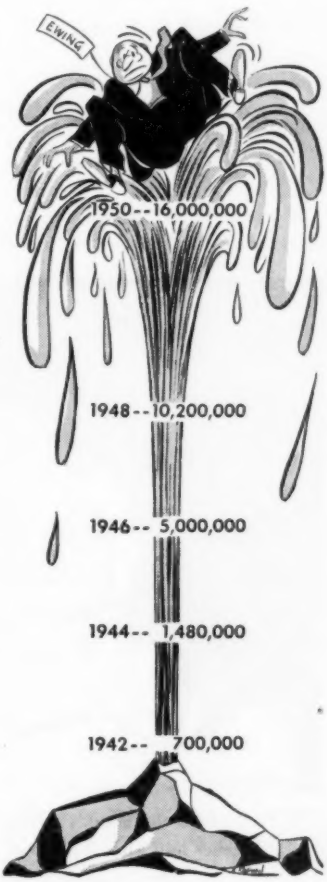
At the beginning of the year there were sixty Blue Shield plans, of which five offered service contracts, twenty-two offered cash indemnity, and thirty-three featured combinations. Now, however, no less than ten of the indemnity plans have switched (or expect to switch) to full- or part-service contracts. Obviously, this could not occur without the interest and approval of local doctors.

Again, witness the movement toward higher income limits for service benefits. The Medical-Surgical Plan of New Jersey is ready to go from $2,850 to $5,000, pending only approval of the state insurance commissioner. The Montana plan has jacked its limit to $5,000, the California plan to $4,000. Michigan Medical Service is shooting for $5,500.

In extent of benefits, as well as in income brackets, the trend is toward wider service. Nowhere is any back-tracking evident on either score. Current changes in benefit structure aim mostly at inclusion of in-patient medical services hitherto neglected. Hospitalized pneumonia cases, for instance, are now covered by a majority of the plans.

As for comprehensive coverage, it's still a matter of much talk and little action. Since actuarial experience comes slowly, few people expect rapid progress toward all-inclusive medical care insurance in the near future. By early next year

ENROLLMENT IN BLUE SHIELD PREPAY PLANS, 1942-1950



Blue Shield expects to have available the results of its current research on the effects of added benefits on medical insurance contracts.

Blue Shield premium rates are holding fairly steady, despite the trend toward broader service. Here's the current rate picture:

BLUE SHIELD AVERAGE RATES
(per month)

	Surgical	Medical-Surgical
Single person	$0.80	$1.17
Two persons	1.56	2.26
Family	2.06	2.75

A recent shot in the arm for Blue Shield enrollment stems from union bargaining demands in a number of major industries. Michigan Medical Service recently signed up a Ford account covering 250,000 employes and dependents.

Another hefty account—15,000 TVA workers—is expected in Tennessee as a by-product of collective bargaining. TVA will thus, in all likelihood, become the first Government agency to grant the right of employe payroll deductions for Blue Shield.

But wholesale marketing methods aren't all directed at large industrial or Government outfits. Community enrollment campaigns

[*Continued on* 150]

" . . . then the good, red-white-and-blue fairy leaped out of the bushes and kicked hell out of the nasty, pink Congressman who advocated socialized medicine . . . "

Investing $20,000: a Case History

If you're looking for a practical investment plan, read this doctor's story

● Paul Harris was troubled. At 47 he had a solid, $12,000-net medical practice, a nine-room house free and clear, and only a mild systolic murmur. His life was insured for $35,000, plus enough in endowment policies to put his two teenage kids through college. He had two cars in his garage and $10,000 of U.S. savings bonds in his safety deposit box. What bothered him was his bank balance: $24,000.

The account, he knew, was top-heavy. A balance of $4,000, along with his Government bonds, would be ample to meet ordinary contingencies. The remaining $20,000 was idle cash; and he was adding to it about $2,500 each year.

The doctor's financial life had reached the menopause. He needed some kind of investment program. The phrase sent a little shiver up his spine.

Not that he hadn't had the beginnings of such a program all along. His insurance policies, the bonds, the redemption of the mortgage on his house—all were aimed at building up some security for his family. Why not simply more bonds, more insurance?

He began inquiring around among his friends: some of the senior staff men at the hospital, a patient in the brokerage business, a golf partner who ran the trust department of the local bank. They came up with a number of ideas. Paul Harris holed up in his study one evening and sorted them out. They shaped up like this:

¶ Deposit the excess cash in mutual savings banks.

¶ Buy more government bonds—U.S., state, or municipal.

¶ Buy more insurance—paid-up life, endowment, or annuities.

¶ Invest in corporate stocks and bonds.

During the next few weeks the doctor looked into each of these possibilities. Most mutual savings banks, he learned, are prohibited by law from accepting single deposits of more than $7,500. He could distribute his funds among several such banks, but decided it wasn't

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*Lloyd E. Dewey and P. J. DeTuro, *authors of this article, are professor and instructor of finance, respectively, at New York University.*

worthwhile. None paid more than 2 per cent.

He ruled out buying more public bonds for the same reason. State and municipal obligations, his broker friend told him, were exempt from Federal income taxes. This made them popular with upper-bracket taxpayers, whose bidding kept prices far above face value. As a result, the bonds were not a good buy for the ordinary investor. The tax-free feature did not offset the low yield unless the investor's taxes were above the 50 per cent bracket.

As for U.S. Government bonds, the best of these for small investors were the "Series E" variety, like those Dr. Harris already had. They paid 2.9 per cent if held to maturity. They could be cashed at any time and were the safest kind of investment. But the doctor felt that, for the time being $10,000 worth was enough. He wanted a better return on his extra $20,000, plus something in the way of appreciation.

By now an insurance agent had picked up the Harris scent. The agent talked earnestly about how a family head "couldn't carry too much insurance" and how the right kind of policy "forces a man to save regularly." But he couldn't deny that, no matter how you slice it, no insurance policy today yields more than 2½ per cent.

At that, he almost put over a sale.

"You should have discussed this with me before the honeymoon."

The doctor's $20,000, the insurance man pointed out, would buy a life income of $151 per month, beginning at age 65. And by adding $2,400 a year until then, Dr. Harris could boost this retirement income to $460 a month.

He was much tempted to sign up. A number of his colleagues had gone for the annuity idea, and one of the older men he'd talked to at the hospital strongly recommended it.

But there was a catch. Paul Harris couldn't get over the way living costs had gone up since before the war. Maybe the price rise was over, maybe not. How would he feel if he socked out nearly all his life savings for a fixed income, then eventually found he couldn't live on that income?

The doctor decided that, though he might some day buy an annuity, he wasn't yet old enough to invest his money that way. He needed protection against possible long-term inflation.

So what it all boiled down to was stocks and bonds. He wasn't any too happy about that, either. The '29 crash had come during his last year as an interne. He remembered what it had done to his father. He remembered, too, that his father had been playing the market on margin, and had a weakness for little-known mining stocks. Paul Harris had other ideas.

The next Saturday afternoon he stopped by the town library and borrowed a book called "Invest-

The Old Army Game

● As every ex-medical officer knows, venereal disease is not only a problem in the armed forces—it is a career. Control procedure is about the same in Army, Navy, and Air Force. Main idea is to expose the men repeatedly to a VD lecture that is a gala duplicate of the stage bill at the Roxy.

First comes the movie. A fatherly-type Hollywood actor, portraying the doctor, discusses "clap" with the same bland earnestness he recently displayed as family lawyer in a film of more general consumption. (Occasionally a rookie who has not already seen the show umpteen times stirs with excitement: Why, the soldier having his blood tested up there on the screen is actually Gary Glamour!)

The lights go on, and somebody nudges the chaplain. He gets up and explains, with quiet embarrassment, that *good* men don't get VD. Next it's the company commander's turn. In the old days he was en- [*Continued on* 127]

ment for the Millions," a publication of the Nonesuch Press. Whether the title referred to millions of investors or to millions of dollars, he wasn't quite sure. But he took the book home and read it. It turned out to be pretty sensible—up to a point.

The book spelled out a number of things that to Dr. Harris had been only hazy notions. Here's a capsuled version of what he got out of it:

"*Objectives.* First decide what you're primarily after: safety, income, or prospect of capital gain. You can have some of all three. But the more you have of any one, the less you'll have of the others. In making up your mind, consider your age, health, earning power, family obligations." (Dr. Harris decided on a middle course: reasonable safety of principal, an income of around 5 per cent, and a little play for his money.)

"*Diversification.* Spread your funds among selected industries, companies, types of securities. Very generally speaking, bonds are safest; but they offer the lowest income and the least chance of appreciation. Common stocks are riskiest, but some offer attractive income or opportunity for capital gain. Preferred stocks rank in between.

"*Timing.* The best investment program can go haywire if it's timed wrong. Theoretically, a business boom lifts stock prices, lowers bond prices; and *vice versa* in depression. But since the time of the New Deal, Government and industrial bond prices have climbed steadily, without regard to the business cycle. Stock prices still fluctuate with business and profit prospects, but are more sensitive than ever to political and world events. To illustrate: Industrial profits are now far above the 1929 level, but stock prices are less than half their 1929 peak.

"*Timing Methods.* Two principal kinds are in use: (1) Analytical. The investor weighs all known fac-

[*Continued on* 155]

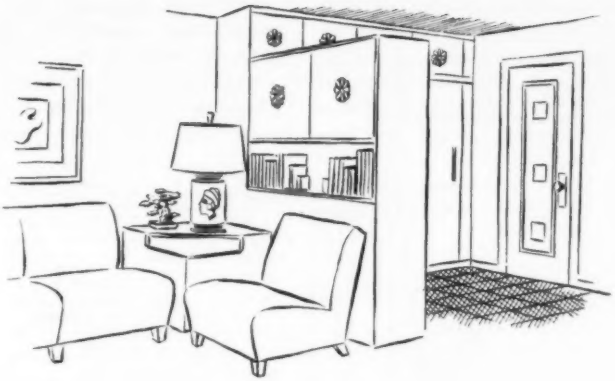
Negotiable

● The patient whose history card I was filling out told me she was a spinster. So, when I came to the space for listing number of children, I automatically put down "none." "But, Doctor," she said, "I have a 13-year-old daughter."

"I thought you told me you were an old maid," I said.

"I am," she replied. "But I'm not a stubborn old maid."

—M.D., ARKANSAS



Patients' Hats and Coats

• Even if you weren't snowed in last winter, there were probably times when your reception-room coat racks were snowed under. Now that April showers are in season, you may still have a full quota of patients' hats, coats, and umbrellas stacked

Storage wall, shown at top and right, separates the entrance-way from the reception room.

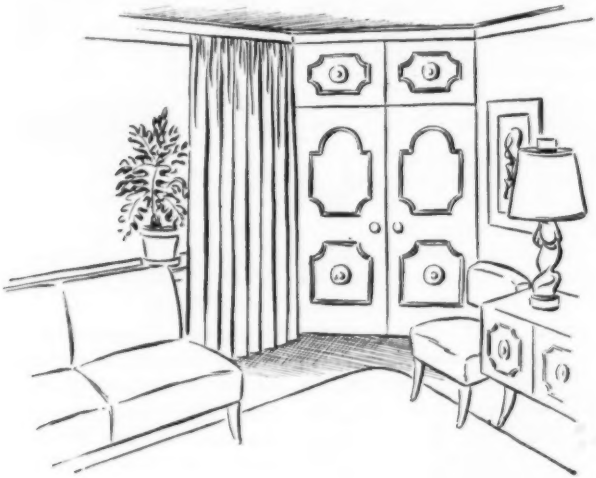
in every corner of your reception room. What to do about it?

You may find some of the answers in the sketches shown on these pages. Each design is aimed at utilizing an area that now rates as "dead space" in many a medical office. The structures shown can be built inexpensively by any good carpenter. They fit unobtrusively into corners, hallways, foyers, and similar spots. The designs can be scaled up or down to suit your individual needs.

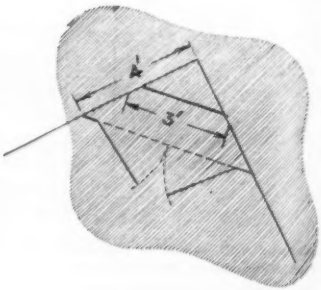
Whether you pick one of these designs or some modification of your own, try to provide these essentials:

¶ Plenty of room for coats to hang freely. (Don't force your patients to choose between keeping their coats on and wrestling with an overcrowded coat rack. The extra space needed is probably available; just look around for it.)

¶ Generous shelf space for hats. (As a rule, the shelf idea works out more successfully than hooks or



Double-door closet, blueprinted below, fits into corner of a small office. Carving on doors makes it a decorative reception-room asset.

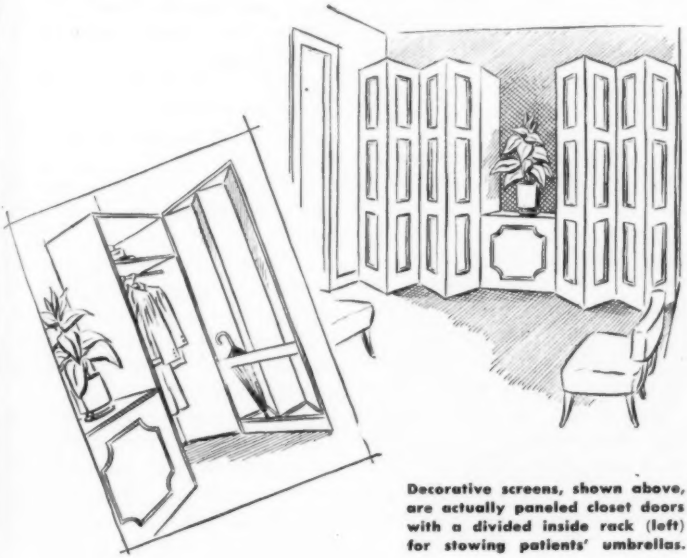


Slanted shelf with pegs is handy for hats. Doorless closet such as this creates a minimum of obstruction in narrow or crowded corridor.

pegs. Hats hung on the latter are all too likely to end up on the floor.)

¶ An easily-cleaned storage space for rubbers and overshoes. (This can often be provided by lining the bottom of a built-in closet with linoleum or similar material.)

¶ A drip-proof rack for umbrellas. (A corner of your coat closet can easily be set aside for this purpose. It's a good idea *not* to place the standard umbrella stands around your reception room. Smokers are too prone to flip butts into them, no matter how many ash trays are handy.) END



Decorative screens, shown above, are actually paneled closet doors with a divided inside rack (left) for stowing patients' umbrellas.

Your Role in the AMA Campaign

Private practitioners asked to take a major part in putting across medicine's case

● To many a physician, medicine's post-war public relations have been as unpredictable as a pre-war television set. But when the AMA's $3 million National Education Campaign came into focus last month, one thing became clear: If the profession's story is to be told to the public, individual doctors will not only have to pay for the program but will have to do much of the telling.

Immediate objectives are to beat the Truman-Ewing compulsory health insurance proposals and to boost enrollment in voluntary plans. This job is being directed by Publicists Clem Whitaker and Leone Baxter, who masterminded the three-year battle against a compulsory program in California.

A longer-range objective is public education on the virtues of private practice, with emphasis on U.S. health standards as against those of the rest of the world. This phase of the campaign will be guided by the AMA's executive assistant, Lawrence W. Rember.

The Whitaker-Baxter plan envisions a giant community campaign, with doctors in the role of door-to-door solicitors. Explains Whitaker: "The AMA and the local societies cannot win this fight; but their members can. We need every doctor talking to his patients and to community leaders, urging them to write their Congressmen and to stir their friends into action."

As soon as the W & B blueprint was made known to state societies, many swung into action. Society officers last month began urging members to:

¶ Act as intermediaries between prepay plan salesmen and businessmen who may want coverage for their employes.

¶ Encourage patients to get voluntary health insurance coverage.

¶ Explain to patients how the Truman-Ewing program would affect the quality of medical care.

¶ Ask local lay groups to take a formal stand against compulsory health insurance.

To give doctors ammunition for their person-to-person work, W & B scheduled two pamphlets for early distribution. Others were due to follow. W & B started recruiting big-name laymen for a new "Ameri-

can Committee for Health Security." Many would join the fight, it was thought, when shown how they could make their influence felt.

These tactics, by last month, had already begun to pay off. The American Bar Association reiterated its stand against legislation that would subject "medicine to Federal control and regulation beyond that presently imposed." The American Farm Bureau Federation, with 1¼ million farm-family members, telegraphed the Senate Committee on Labor and Public Welfare: "Tremendous progress has been made in meeting our health problems . . . We have consistently opposed compulsory health insurance . . . because we believe the desired result can be achieved more completely, more satisfactorily, and more democratically by other means."

To finance the W & B part of the campaign, AMA trustees have allotted $1 million. Most will go for literature production costs; none is earmarked for radio or newspaper advertising, which Whitaker considers "expensive and politically unwise at this time." The $1 million thus tabbed represents about one-third of the expected income from the $25 levy voted by the House of Delegates.

If about 85 per cent of AMA members pay up, as association officers believe, another $2 million will be available in reserve for Phase 2 of the drive.

Precisely how this reserve fund will be spent was not known last month. The trustees, who control the P.R. campaign, had not laid down detailed policies on which Executive Assistant Rember could build his plan. Nor had any clear line been established between Rember's program and the W & B operation, which includes getting across the story that "with all its shortcomings, with all its inequalities, American medicine is still better than anything else yet devised." To private practitioners these problems are far from academic. Patients can ask any number of delicate questions for which doctors may have no answers until the AMA irons out the details of its stand.

The most pressing points are these:

¶ *What to do about a national enrollment corporation for medical care plans?* Last December, the delegates disapproved a joint Blue Cross-Blue Shield health service. But, with the AMA now demanding a spectacular jump in prepay-plan

enrollment, Blue Shield officers ask: "How can we sign up big national accounts when we have no mechanism for equalizing premiums and benefits, or for central billing and collecting?" The trustees have decided to let the House of Delegates answer that one.

¶ *What to do about medical co-ops?* The co-ops could add considerably to the total of voluntary plan enrollment. But still lacking last month was a set of standards by which local medical societies could approve co-ops. AMA and co-op officials were scheduled to meet this month to consider a proposed list of standards. A truce in the long-standing feud between organized medicine and the co-ops appeared nearer than ever before.

¶ *What to do about the National Physicians Committee?* Fears that the AMA campaign may follow the pattern of NPC operations are expressed in some quarters. Says AMA General Manager George Lull: "We'll turn no money over to the NPC. It's a separate organization." But some state society representatives urge outright disavowal of NPC. This could be authorized only by the AMA House of Delegates, which has twice reaffirmed approval of NPC.

¶ *What to do about the 148-doctor complaint against the $25 assessment?* A group of nationally-known medical men have labeled the AMA attitude toward medical care problems as one of "unwillingness fully to acknowledge the need for improvement." They claim that the delegates' instructions on how assessment funds are to be spent are so vague that the program is subject "to the possibility of grave abuse." In retort, the AMA trustees have charged the critics with a "disservice to the cause." [Complete texts of protest and retort appear at the end of this article.]

Some association officers are worried privately that this skirmish may slow assessment collections. A

[*Continued on* 133]

Dead End

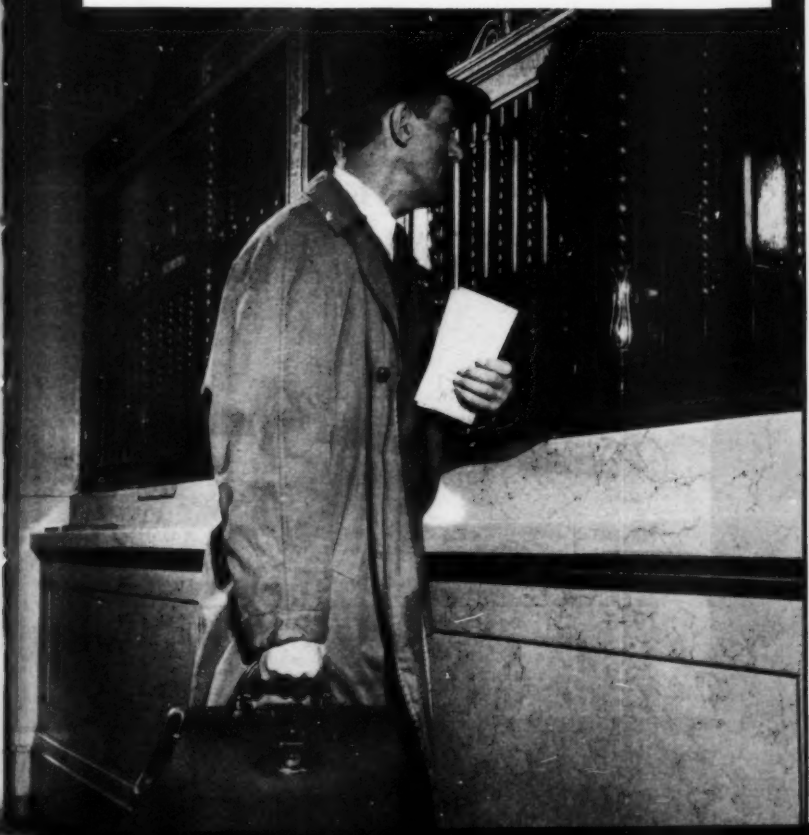
● Into our cancer clinic came an elderly gentleman from deep in the Ozarks. Covering the dorsum of one hand was an ulcerated, fungating carcinoma. Said one of the house staff: "Grandpa, why in the world did you wait so long before you came to the doctor?" Replied the ancient sage: "Well, Son, I knew this thing was a cancer. But I didn't see no need to hurry. It was down agin the bone where it couldn't go no further."

—WILFRED E. WOOLDRIDGE, M.D.

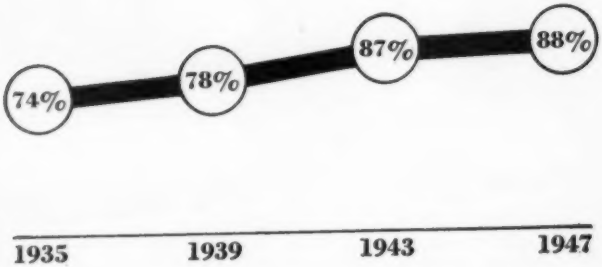
Your Collections

A report based on the Sixth MEDICAL ECONOMICS *Survey*

By William Alan Richardson



AVERAGE PERCENTAGE OF BILLS COLLECTED BY INDEPENDENT DOCTORS IN RECENT YEARS



One-third of all independent physicians collect at least 95 per cent of their accounts.

Only one half of 1 per cent of all independent physicians collect less than half their accounts.

General practitioners collect 87 per cent, on the average; full specialists, 90 per cent.

The percentage of accounts collected is affected only slightly by one's specialty and by the size and location of one's community.

NOTE: Data above are based on reports for 1947 from independent M.D.'s.

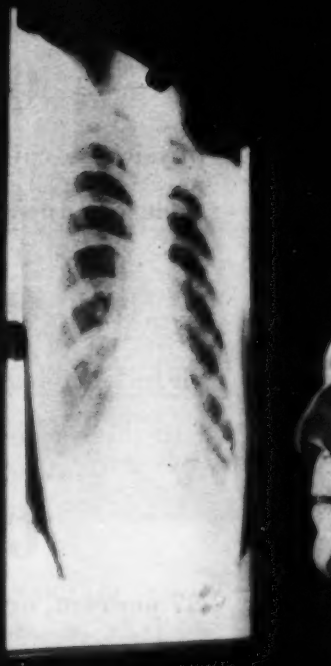
MEDICAL ECONOMICS' Sixth Survey

● Every four years MEDICAL ECONOMICS surveys the economic status of U.S. physicians in active, private practice. The study shows average incomes and expenses, time spent in professional work, patients seen daily, personnel employed, etc. Results are analyzed according to geographic location, community size, years in practice, specialty, income, and sex.

The survey for 1947 was planned and executed by the editorial staff of MEDICAL ECONOMICS, with the aid of technical consultants in research and statistics. Among such consultants were heads of the Census Bureau and of the National Income Division, U.S. Department of Commerce.

Material for the study was obtained by means of a reply postcard bound into each of the 135,500 copies of March 1948 MEDICAL ECONOMICS. A total of 6,706 physicians responded.

Since a sample of 6,706 was considered statistically larger than necessary, a free hand was used in eliminating cards that had not been filled in fully or about whose accuracy there was any doubt. Still other cards were eliminated in the process of weighting the



returns. The result was a working sample of 4,878 replies.

The returns were weighted according to four control factors: geographic area, community size, years in practice, specialist or general practitioner. After weighting, the sample conformed closely with the distribution of all active, private physicians, according to the four controls used. Deviation did not exceed 1.1 percentage points.

The data on the survey returns were then transferred to punch cards and tabulated mechanically. (More details about the method of conducting the survey were given in the September issue.)

The active, private physicians surveyed derive the bulk of their collective income from fees. Many also have some salary income. The men who get LESS than half their income from salaries are designated here as *independent*. Those who get MORE than half their income from salaries are called *salaried*.

Sixth MEDICAL ECONOMICS Survey results will be published in a series of articles. If the volume of requests warrants it, the series will be published as a booklet.

The September-March issues reported doctors' incomes, expenses, hours, patient load, time spent per patient, time given to charity. This issue reports on collections and assistants.

Doctors' Assistants

A report based on the Sixth MEDICAL ECONOMICS *Survey*

By William Alan Richardson

About 59 per cent of physicians employ secretaries. About 21 per cent employ technicians. About 3 per cent employ other physicians.

Most medical men who employ a secretary have but one. Most doctors who employ a technician or another M.D. also have but one.

For every thousand general practitioners there are 570 secretaries and 201 technicians.

For every thousand full specialists there are 850 secretaries and 338 technicians.

NOTE: Data above are based on reports for 1947 from independent M.D.'s.

AVERAGE NUMBER OF SECRETARIES AND TECHNICIANS PER THOUSAND SPECIALISTS IN INDEPENDENT PRACTICE

1947

Specialty	Secretaries	Technicians
Dermatology	810	238
Ear, nose, throat	861	165
Eye, ear, nose, throat	1,020	214
Internal medicine	819	575
Neuropsychiatry	879	121
Obstetrics/gynecology	842	322
Ophthalmology	970	139
Orthopedic surgery	868	342
Pediatrics	871	314
Psychiatry	641	103
Roentgenology/radiology	650	1,250
Surgery	901	292
Urology	875	200
All other specialties	651	419

AVERAGE NUMBER OF SECRETARIES AND TECHNICIANS PER THOUSAND INDEPENDENT PHYSICIANS AT SIX INCOME LEVELS

1947

Gross Income	*Secretaries*	*Technicians*
$ 5,000	165	19
10,000	406	57
15,000	586	140
20,000	790	264
25,000	867	370
30,000	874	428

Survey Sidelights

[NOTE: *These findings are based on average figures for independent physicians in 1947. See immediately preceding pages.*]

¶ Of all the specialists, psychiatrists and dermatologists collect the highest proportion (93 per cent) of their accounts.

¶ Doctors in the Middle Eastern states collect the largest proportion (90 per cent) of their bills. Even in the Southeast, where collections are lowest, the record (83 per cent) is not bad.

¶ Collections range from 92 per cent in cities of more than a million population to 85 per cent in cities of 5,000-50,000.

¶ Oddly, doctors with secretaries collect 87 per cent of their accounts while doctors without secretaries collect 89 per cent. This unnecessary condition could be corrected by better selection, training, and supervision of secretarial personnel.

¶ In the relatively brief span from 1943 to 1947 the percentage of doctors who employ secretaries increased from 56 to 59 per cent.

¶ For every 1,000 physicians in 1947 there were 650 secretaries, 240 technicians, and 36 M.D.-assistants.

¶ The highest concentration of medical secretaries and technicians is found in cities of 50,000-1,000,000.

¶ For every 1,000 doctors who see 50-60 office patients a day each, there are twice as many secretaries and almost five times as many technicians as for every 1,000 doctors who see 10-20 office patients a day each.

¶ The biggest employe roster reported by a solo physician totals 18 (4 secretaries, 12 technicians, 2 M.D.'s). The employer is a New England internist. His annual payroll is $34,500.

The American Academy of Pediatrics

A close look at one of medicine's most talked-about specialty groups

• "A conservative, highly respected body of specialists," one observer calls it. Another begs to differ: "The organization has fallen into the hands of persons committed to the collectivist philosophy." Caught in this right-left cross fire, the 18-year-old American Academy of Pediatrics goes cheerfully on, plugging away for better child care and not much minding where the chips fall.

Clashing opinions about its activities are an old story to the academy, which was conceived and born out of controversy. It all started back in the early years of the depression, when pediatricians became keenly aware of the social and economic implications of their work.

A show-down developed over a Congressional proposal to revive the Sheppard-Towner Act—a law that encouraged state health departments to set up child-hygiene divisions. The AMA opposed reenactment. A rump group of seventy-five pediatricians, led by Dr. Clifford G. Grulee, took exception to the AMA stand. They convened on their own and announced support of the measure. Out of this meeting grew the American Academy of Pediatrics.

The society has added about a hundred members every year. It now includes most of the country's pediatricians. About 80 per cent of its 2,500 fellows are in private practice. All but 300 are diplomates of the American Board of Pediatrics; in fact, for the last decade, only diplomates have been eligible for membership.

G.P. Link

But the academy shows no signs of snobbery toward the general practitioner. Some specialty groups devote much energy to deploring the consequences of G.P. poaching on their preserves. Not so the AAP; it makes a point of trying to give family doctors a better understanding of pediatrics. When the Children's Bureau released a film on rheumatic fever, the academy was quick to criticize the bureau for underplaying the general practitioner's role.

The AAP is an *enfant terrible* to some of the more conservative members of the profession. They think it plays footie with the Fed-

Top officers of the American Academy of Pediatrics include Dr. Warren R. Sisson (left), president, and Dr. Clifford G. Grulee (below), secretary and chief administrator.

eral Security Agency, the state health departments, the Children's Bureau, and other government units not noted for their devotion to free enterprise. They point out that the academy's newly completed child-care survey was, for a while, headquartered in space loaned by the Public Health Service, and that the Government underwrote a third of the project's cost. As a clincher, critics of the academy say it has gone overboard on the idea of Federal subsidies to medical education.

AAP spokesmen retort that a pediatrics society could hardly function without close contact with governmental children's agencies. They say that good relations between the academy and public officials have furthered private enterprise—because the AAP has more influence with government agencies than overtly hostile medical societies have. In 1944, for instance, the academy took sharp issue with the Children's Bureau over Government efforts to regulate fees and conditions of practice through the EMIC program. The bureau had expected opposition from other medical societies and was prepared to ignore it. But when the usually friendly AAP set up a howl, there was a quick call for a conference. Result: A number of wrinkles in the EMIC scheme were ironed out.

Fellows of the academy are hurt rather than angered by the occa-

sional charge that they seek to subvert AMA principles. Dr. Grulee, AAP secretary, says: "We will not take any action contrary to decisions of the AMA. At least, I'll be very much surprised if we do." While the academy has the endorsement of the AMA, the latter's House of Delegates only last fall adopted a resolution aimed at the AAP: "Minority specialty groups," it read, "should be restricted from advancing proposals affecting the interests of the public or the profession before proper endorsement by the American Medical Association."

Perhaps the most outspoken critic of the academy is the Association of American Physicians and Surgeons. Last year Dr. William Black, then AAPS president, hit the ceiling over an AAP committee report on the educational subsidy question. He issued an open letter that read, in part: "Only an impractical dreamer could write such a report or believe that adoption of any part of it would lead to anything but compulsion, coercion, bureaucracy, stateism, and despotism. The report clearly, baldly, and unequivocally cleaves to the Communist social philosophy."

To which one AAP officer replied: "The AAPS does not have the approval of the American Medical Association. We do."

The tempo of AAP affairs re-

Dr. John P. Hubbard (above) directed the academy's child-care survey. Dr. Martha Eliot (right) sides with the AAP minority that plumps for compulsory sickness insurance.

Do your patients find it difficult to cut down on coffee?

YOU PROBABLY have had occasion to advise a patient to cut down on his coffee consumption.

Perhaps you felt he should give it up altogether but decided it was too difficult for your patient to do—and so suggested he cut down on coffee.

Unfortunately, cutting down on coffee is often very hard. There's always the tendency to drink another cup. The tendency to overdo.

That's why we feel Sanka Coffee is the perfect answer to *any* patient affected by caffein in *any* amount.

Patients can drink all the Sanka they want without the slightest caffein effect. There's no need to cut down at all—or to go without the enjoyment of a good cup of coffee.

For Sanka is a real coffee—a delicious coffee—that is 97% caffein-free.

We suggest that you try drinking Sanka. We know you will appreciate what a fine coffee it is. And—if *you* are affected by caffein—it may very well be the answer to your own problem, as well as that of your patients.

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flects an accent on youth. Not that the fellows are wet behind the ears; many of the country's senior pediatricians are high in academy councils. But the atmosphere of meetings and the pace of program activities show a zest usually associated with "young ideas." While private pediatrics is a highly competitive field, the older men seem genuinely interested in helping the younger members. Absent is the "closed-shop" attitude that has barred younger doctors from positions of leadership in some other specialties.

Academy meetings are well attended. The November 1948 session, for example, drew 1,400 doctors. An AMA interim session the same month drew only thrice this figure despite a membership fifty times that of the AAP. Impartial observers agree on the high caliber of the academy's scientific programs. What's more, sessions are run without the hitches and snags common to many large conventions. Registration, traffic control, exhibition layout, programming, timing, space, and acoustics—all reflect expert handling.

Academy organization is based on nine geographical districts. In each district, a chairman is elected by the fellows of that area. The nine chairmen, plus the president and vice-president, constitute the AAP policy-making body: the executive committee.

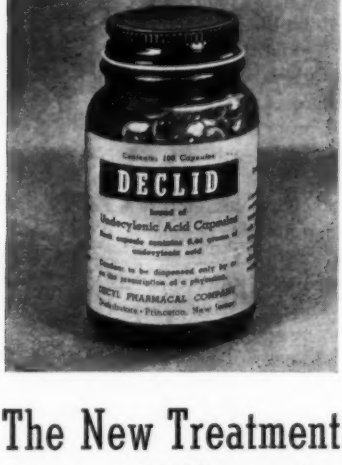
Each district chairman is assisted by a local committee. Here

the actual liaison between pediatricians and lay officials is established. If, for instance, the academy recommends a change in standards for school physicians, it is up to district committeemen to make the necessary contacts with local boards of education.

General administrative officer of the AAP is its secretary, Dr. Grulee. He and a staff of five handle the day-to-day routine of the society, the mapping out of convention details, and the financial and membership records.

The academy's only headquarters is Clifford Grulee's office in Evanston, Ill.

The AAP operative set-up—a central committee plus nine district committees—has been challenged as precluding true representation of rank-and-file members. A house of delegates has been proposed to correct this. The proposal has, however, made little headway. Even the fact that the American Medical Association has such an



The New Treatment for Psoriasis and Neurodermatitis

● Undecylenic acid given orally in psoriasis and neurodermatitis is a new therapy reported by Henry Harris Perlman, M.D., of Philadelphia, in the Journal of the American Medical Association, issue of February 12, 1949.

The special grade of undecylenic acid used by Dr. Perlman in his clinical studies is now available for prescription under the brand name Declid, in 0.44 g. gelatin capsules.

Only this special grade of undecylenic acid has been studied and reported on, to date. The pharmacology and mode of action of the drug are still under study. No generalized statement can be made of the external manifestations of the action of the acid. Some exfoliation can be expected shortly after administration is started. There is usually prompt relief from itching.

Regression of lesions occurs in different forms varying with the individual, the duration of the disease, the site of the lesions, and the period of treatment.

In a significant number of cases improvement has been noted in from one to two weeks, even in cases where no such changes have been previously observed during months under other treatments.

Physicians are invited to write for literature regarding dosage and other features of this new treatment.

DECLID

BRAND OF UNDECYLENIC ACID

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arrangement has failed to convert most AAP fellows to the idea.

Unlike most U.S. specialty societies, the American Academy of Pediatrics has substantial South American representation. About 200 fellows are in countries south of the border. Chief factor in their enrollment has been energetic field work by Dr. Grulee. Since the American Board of Pediatrics cannot conveniently certify training facilities below the Rio Grande, applicants are required to pass tests administered by the district chairmen.

The academy was catapulted to page-one prominence last year as a result of its monumental survey of child-care needs and facilities in the United States. This million-dollar project signaled the academy's maturity, set up a model for other specialty societies, and confirmed AAP willingness to take a stand on highly controversial issues.

Prior to the academy survey, some authorities insisted that child care in this country was inadequate. They proposed remedies ranging from partial subsidies to socialized medicine. Others said that American children were getting the finest care available, that the profession should not be harassed by Government reforms. The AAP said, in effect: "We think child care here is pretty good, but we honestly don't know. Let's get the facts first and talk remedies later."

It was the academy's feeling that the survey might spotlight areas of weakness that could be strengthened without radical changes. In

Fun at the Doctor's

[*"To reduce the tedium of waiting to consult the busy physician, modern reception rooms offer the patient games, puzzles, late musical recordings . . ."* Medical supply magazine.]

● Strolling absently into Dr. Witherspoon's office for my annual check-up, I reached for a magazine on the table by the entrance.

"Uh-Uh! No reading!" A dark, sultry young woman flashed me a toothy smile. "Perhaps, while you wait, a rumba lesson—no?"

"No," I said. Blushing a little, I backed off, trying to orient myself. Since my last visit, [*Continued on* 121]

facts concerning

Pen-Aqua

*A new and highly practical penicillin formulation for **aqueous** injection at **24-hour** intervals.*

What it is—PEN-AQUA provides Procaine Penicillin G and buffered Potassium Penicillin G in combination for constituting an aqueous solution-suspension for intramuscular injection.

What it does—The soluble Potassium Penicillin is absorbed within an hour following injection, thus providing a correspondingly high initial blood concentration of penicillin to overwhelm invading bacteria at the outset.

The relatively insoluble Procaine Penicillin is absorbed slowly, thus providing a repository effect which sustains therapeutic penicillin blood levels for 24 hours or more in the majority of patients.

How to use it—PEN-AQUA is quickly prepared for use by introducing the directed quantity of Water for Injection, USP, or Isotonic Solution of Sodium Chloride, USP, directly into the sterile PEN-AQUA vial, with thorough shaking before the withdrawal of each dose. So constituted, each cc. contains 300,000 units of Procaine Penicillin G per cc., plus 100,000 units of Potassium Penicillin G per cc., in uniform suspension which passes through the needle freely. PEN-AQUA is absorbed completely, without nodule or cyst formation.

When to use it—PEN-AQUA may be used in all conditions amenable to systemic penicillin therapy, in cc. doses corresponding in frequency with that employed with Penicillin in Oil and Wax (Romansky Formula)—generally, one cc. each 24 hours, 12 hours in certain severe or refractory infections. PEN-AQUA is intended for intramuscular use only. Suspensions retain their potency for one week under refrigeration. In the dry state, PEN-AQUA retains full potency for a year.

How supplied—PEN-AQUA is available in *multiple-dose vials* containing 1,500,000 units of Procaine Penicillin G, plus 500,000 units of buffered Potassium Penicillin G, with space provided for the introduction of 4.5 cc. of diluent; also in *single-dose vials* containing 300,000 units and 100,000 units of Procaine and Potassium Penicillins G, respectively, with space provided for the introduction of 1 cc. of diluent.

Pen-Aqua

Bristol Laboratories' Trademark for Crystalline Procaine Penicillin G with Buffered Penicillin G Potassium for aqueous injection

any event, future legislation on child care could be anchored in truth, not in fantasy.

The survey began with a 1944 enabling resolution and $16,000 of academy funds. Its final cost: nearly $1 million. The survey staff, at its peak, numbered 170 persons. It was headed by Dr. John P. Hubbard, whose work won him the 1948 Parents' Magazine award for "distinguished service to children." One-third the total cost of the project was borne by the Federal Security Agency. About one-fourth was contributed by the National Foundation for Infantile Paralysis. Other foundations and commercial companies, in the aggregate, put up more than $200,000. Many state and county medical societies, as well as local health departments, donated money or facilities. The academy's own financial contribution, while small compared to the total, drained its treasury. For a while, at least, the AAP has had to postpone plans for a new headquarters building.

Doctors Quizzed

The nucleus of the survey was a questionnaire sent to each private physician in the country. It asked him to indicate how many children he saw on a specified date, how much training he'd had in pediatrics, how much time he devoted to such work, and so on. Ordinarily, such a questionnaire might be ex-

"And they say his wife took an interior decorating course!"

Before use:
Crystal filter is pure white

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Filter turns dark as it traps nicotine and tars.

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The crystal filter cigarette holder that definitely reduces nicotine and tars

You can, with confidence, permit your patient the solace of smoking with much of the harmful effect removed. ■ The Denicotea cigarette holder utilizes an efficient filter of silica gel crystals to trap and absorb irritating nicotine and tars ■ We shall be glad to send you a report on Denicotea by the U. S. Testing Laboratories.

Introductory Offer to Physicians—Write for Denicotea holder. $1. postpaid (regular price $2). Lady Denicotea $1.75 (regularly $3.50). Alfred Dunhill, Dept. E, 660 Fifth Ave., New York 19.

pected to produce responses from about 10 per cent of the recipients. In this survey, more than 60 per cent of the doctors replied. One reason was the top-notch field work by AAP district committees, which kept needling physicians to send in their answers. Another reason was the active cooperation of the state medical societies.

The survey included personal visits to most of the 3,000 hospitals that admit children. To get the facts about pediatric training, personal visits were also made to all the approved medical schools throughout the country.

Although the final report has not yet been widely distributed, some local results have become apparent. In Connecticut, for example, the state's child-welfare set-up is getting a New Look, based on facts brought out by the AAP survey. In North Carolina six new premature-infant centers have been opened. The Commonwealth Fund, which publishes only top-drawer scientific reports, is beginning to distribute the two-volume report on the AAP survey this month.

The survey is by all odds the biggest task ever undertaken by the academy. It has brought the organization into intimate contact with social, health, welfare, and educational agencies in the four corners of the nation. And it has welded the entire academy membership into a smoothly functioning unit.

Some doctors fear that the AAP now has a bear by the tail. The survey found a number of spots where children were not getting the kind of care worthy of American medicine. This could be grist for the mill of the state-medicine campaigners.

But Dr. Grulee is insistent that the AAP "does not want the bureaucrats to do the interpreting." The academy plans to handle the publicity, including the interpretation, on its own. The interpreting will be done through newspaper and magazine articles, lectures, and pamphlets. The academy has set its sights on certain special media, like The March of Time, which can document the survey without propaganda.

The survey has overshadowed but not eliminated other AAP activities. The academy works with all sorts of groups interested in child welfare. In every state there are AAP fellows in liaison with parent-teacher associations, scout organizations, YMCA's, and the

* HANDITIP *

Bill Collector

A pediatrics bill addressed directly to junior not only flatters the child, but often produces quicker results than when addressed to the man of the house. The novelty of the scheme keeps your bill from being filed and forgotten.

—M.D., CONNECTICUT

* * * * *

like. When a state or Federal department wants to put out a pamphlet about child care, the academy offers its services. If a bill important to child health is slipped into any legislative hopper, an AAP representative is on deck when the hearings start. If a social agency is working on a code to discourage black-market baby adoptions, an academy member will probably turn up at every meeting.

Let any agency take action that might be detrimental to child health, and the AAP will be on its neck. Sometimes the academy is suave about it, sometimes blunt. Some organizations that have drawn AAP fire feel the academy is a little quick on the draw. But no one has ever said he didn't know when the AAP was around.

With the survey over the hump, the academy has turned to another big issue: Federal aid to medical education. Every specialty group feels that medical schools do not give enough time to its specialty. But the AAP has facts to back up its complaint. Since one-third of a G.P.'s time is spent taking care of children, the academy can make out a good argument for giving pediatrics an A-1 priority in medical-school and post-graduate teaching programs.

Since nearly all medical schools and teaching hospitals are in the red these days, the Government would like to subsidize a program of pediatric training. The American Academy of Pediatrics says, in effect: "We don't like a Federal subsidy. Let's see if private resources can meet the need for better pediatric training. If they fail, we must endorse the acceptance of Federal funds."

This stand has not made the AAP any more acceptable to the conservative wing of the profession. One medical journal warns that the AAP position "has opened the door wide for Federal invasion of all medical education."

Another observer criticizes the academy on grounds that a bid for Government funds should come through organized medicine as a whole, not through any one specialty group.

But, despite attacks from some quarters, the academy feels it is taking the only honest position possible in view of its goal of better pediatric training for all doctors. Once again—as befits its eighteen-year history—the AAP is willing to let the chips fall where they may.

—E. K. BUCHANAN

liver disorders

cirrhosis
fat infiltration
functional impairment
toxic hepatitis
infectious hepatitis

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(pronounced meth' is kol)

A synergistic combination of METHIONINE, CHOLINE and INOSITOL in a LIVER-VITAMIN B COMPLEX BASE . . . lipotropic substances which favor the transport of fat from the liver to the fat depots of the body . . . for prophylaxis, retardation and specific therapy in reparable liver damage.

each tablespoonful or 3 capsules contain:

dl-Methionine	333 mg.
Choline	250 mg.
Inositol	166 mg.

together with the natural B complex from 12 grams of liver.

Supplied, in bottles of 100, 250, 500 and 1000 capsules and 16 oz. and gallon syrup.

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X-Ray Equipment for the G.P.

A revealing report on one doctor's experience with an office unit of his own

• "Should I install X-ray equipment in my office?"

Increasing numbers of general practitioners are asking themselves that question. So are some men in such specialties as pediatrics, internal medicine, and otolaryngology. The answer is not always clear, being tied up with matters of medical economics, of professional responsibility to patients, and even of professional ethics.

Why so much interest in X-ray?

To be frank, let's admit that the manufacturers of X-ray apparatus are doing their part to stimulate the use of what they have to sell. But their efforts would meet with little success if it weren't for the fact that significant numbers of doctors are finding X-ray a valuable adjunct in general practice.

It is, I believe, generally agreed that the doctor in an isolated community should, if possible, have his own X-ray. I contend that doctors like myself, practicing in urban centers, should also own such units.

Whether X-ray equipment is adaptable to a given practice depends on the answers to these questions:

1. Can I make sufficient use of X-ray in my type of work?
2. Will X-ray help to improve the quality of the service I render?
3. Will the installation of X-ray be a sound move financially?
4. How will X-ray affect the use of my time?
5. How will the ownership of a unit affect my attitude toward the full use of X-ray techniques?
6. What effect will the installation of X-ray equipment have on the attitude of my patients?

Case Study

In seeking valid answers to such questions, the statistical approach does not appear practical. Polling doctors who already own X-ray equipment would certainly lead to distorted results. Yet those doctors without X-ray experience have no basis for answering these questions.

As an alternate approach, I propose to answer these questions by reporting my personal experience. Admittedly, this is valid only for doctors whose situation is roughly parallel to my own. So, by way of preface, here are some background

[*Continued on* 93]

ARGYPULVIS

. . . in the

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TRICHOMONIASIS

For Home Use by the Patient
2-gram capsule for insertion by the patient

For use by the Physician
7-gram bottles fitting Holmspray or equivalent powder blower

. . . This new adaptation of ARGYROL offers distinct advantages for office treatment and home application

Utilizing for the first time the positive protozoacidal action, with its demulcent and detergent properties, this adaptation of ARGYROL offers the physician an effective weapon in the treatment of Trichomoniasis. The same effective powder form provided for office treatment is also made available for supplementary home use . . . so essential to effective control.*

Composition . . . Physical Properties

ARGYPULVIS contains powdered ARGYROL (20%), Kaolin (40%) and Beta Lactose (40%) . . . finely milled, to provide the fluffiness which makes for easy insufflation, and with an attraction for water which promotes fast action.

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*Reich, Button and Nechtow, "Treatment of Trichomonas Vaginalis Vaginitis," *Surgery, Gynecology & Obstetrics*, May 1947, p. 891.

INTRODUCTORY TO PHYSICIANS: On request we will send professional samples of ARGYPULVIS (both forms), together with a reprint of the Reich, Button & Nechtow report. (Use coupon).

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Name.....

Address.....

City.....State.....

facts about my medical practice:

My office is located near one of Chicago's outlying shopping districts. Most of my patients belong to the "middle class"—white-collar workers with incomes of about $4,000 a year. Since getting out of the Army two years ago, I have been fortunate enough to establish a moderately "comfortable" practice. I see an average of fifteen patients a day and find it necessary to make only two or three house calls a day. About 20 per cent of my practice is industrial, referred to me from a nearby manufacturer. My second-floor office consists of a waiting room, consultation room, and a fairly well-equipped therapy room. Up to now, I've been able to take care of my practice by myself, without the help of a receptionist or technician.

That, then, is the background. On the basis of it, the reader may evaluate the following report in terms of his own situation:

Can I make sufficient use of X-ray in my type of work? During a typical month (July 1948) I saw a total of 315 patients. I employed fluoroscopy, radiography, or both in forty cases, or nearly 13 per cent. Here is an itemized list of what was X-rayed:

22	chests (general check-ups)	
1	lumbosacral spine	
1	forearm	2 legs
3	wrists	1 ankle
7	hands	3 feet

Will X-ray help to improve the quality of the service I render? In numerous instances, X-ray has helped me arrive at exact diagnoses that otherwise might have escaped me. Let me cite an example:

The patient was a 40-year-old salesman, apparently in good health until two days before he came to my office. He complained of tiredness and stuffiness in the head. He had no temperature; his breath sounds were clear in his chest. There was no evidence of friction rubs, and a deep breath produced no pain.

On a routine fluoroscopic and radiographic examination (which, incidentally, is done on all new patients coming to me) a lesion was noted in the lower portion of the left upper lobe, suggesting atypical pneumonia. The patient was sent to bed for a two-week rest, with support of medication. Six weeks after the first radiograph a follow-up film was taken. It was negative for any pulmonary lesion.

Conclusion: If it were not for my roentgenographic findings, this patient's pulmonary lesion would not have been diagnosed.

Will the installation of X-ray be a sound move financially? Various X-ray machines of the same type as mine are available for about $1,000. The necessary dark-room equipment and accessories amount to another $500 or so. This outlay covers the developing tank and solutions, cassettes, screens and film of various sizes, hangers, stationary grid, illuminators, wall-mounted cassette holder, cardboard

Patients with stomach disorders are generally squeamish about their foods or medicines. Your patient's battle is half won if he can look forward *with pleasant anticipation* to 'taking his medicine' instead of being upset or annoyed at the prospect. With the obstacle of objectionable taste eliminated and the patient in the proper frame of mind, the ameliorative action of pleasant-tasting Gelusil* Antacid Adsorbent is consequently enhanced. Relief is almost immediate with Gelusil* Antacid Adsorbent and unlike ordinary alumina gels, it leaves the patient practically free of constipating after-effects.

Indications: Gelusil* Antacid Adsorbent is indicated for the relief of gastric hyperacidity resulting from dietary indiscretions, nervous or emotional disturbances, food intolerances or in peptic ulcer therapy.

*T. M. Reg. U. S. Pat. Off.

Package Description

Dosage: Two teaspoonfuls of Gelusil* Antacid Adsorbent (liquid) or two Gelusil* tablets may be given between meals as often as necessary to relieve symptoms of hyperacidity and promote recovery. Gelusil* tablets are particularly adaptable for the ambulant patient.

Package Information

Gelusil* Antacid Adsorbent is supplied in bottles containing 6 and 12 fluidounces. Gelusil* Antacid Adsorbent tablets are supplied in bottles of 50, 100 and 1000.

GELUSIL

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holders, name-plate markers, film drying rack, dark-room timer, lead rubber apron, and gloves.

A careful analysis of my X-ray records since the apparatus was installed provides the income-and-expense figures shown in the adjoining table. They indicate how much of an asset my equipment has been. I may add that my fees for X-ray work are moderate, averaging about $7.

How will X-ray affect the use of my time? From the figures cited, it is apparent that the doctor is well paid for that portion of his time devoted to X-ray work. I found no difficulty in fitting X-ray work into my regular routine. Much of the laboratory work can be done outside of consultation hours. As mentioned earlier, I have until now been able to do all my own work, without assistance. But an intelligent office girl or technician can quickly become proficient in operating the apparatus and can do much of the radiography while the doctor is otherwise occupied.

In one important respect, the installation of X-ray equipment has greatly economized my own time as well as my patients'. When X-ray examination is indicated, it is usually possible to complete the diagnosis at the first visit. A chest X-ray, for example, can be made and sufficiently processed for wet reading within six minutes. The patient is thus spared the necessity of an additional visit, and treatment can be started at once. [*Turn the page*]

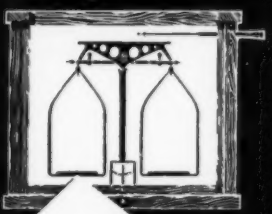
X-Ray Balance Sheet

(Showing monthly income and expense* for a $1,500 X-ray installation)

Month	*Expense*	*Income*
	1947	
Jan.	$24.70	$115.00
Feb.	41.48	80.00
Mar.	9.30	84.00
Apr.	25.78	99.00
May	30.36	108.00
June	25.72	78.00
July	9.30	101.00
Aug.	51.13	130.50
Sept.	37.56	121.00
Oct.	40.66	241.00
Nov.	52.60	174.00
Dec.	49.44	141.00
	1948	
Jan.	9.30	220.00
Feb.	47.15	160.00
Mar.	33.93	282.00
Apr.	42.25	264.00
May	56.28	287.00
June	60.20	336.00
July	58.11	293.00
Aug.	33.94	242.00
Sept.	46.33	276.00
Oct.	9.30	314.00
Nov.	51.32	212.00
Dec.	48.32	293.00
Totals	$894.46	$4,651.50

*Includes cost of supplies, repairs, insurance, electricity, and an allowance for depreciation.

Announcing



a wider margin of clinical safety

d-TUBOCURARINE CHLORIDE SOLUTION-CUTTER

Curare-Chemically Pure Accurately Standardized by Weight

d-Tubocurarine Chloride Solution-Cutter is prepared from the crystalline alkaloid of the highest available chemical purity—specifications exceed the rigid requirements for chloroform extractable residue accepted by the Council on Pharmacy and Chemistry of the American Medical Association.

More Definite Physiological Response—Chemical purity increases predictability, narrows interpretation to a single variable—individual response to the pure drug.

Maximum Pentothal-Curare Compatibility—Chemical purity increases the ratio of pentothal-curare compatibility to maximum limits without precipitation, allowing greater flexibility in the management of the dosage proportions.

d-TUBOCURARINE CHLORIDE SOLUTION STANDARDS FOR CHLOROFORM EXTRACTABLE RESIDUE

Council Requirements: "*residue not to exceed 3.0%*" 97%

Cutter Specifications: "*residue not to exceed 0.3%*" 99.7%

Derived from botanically authenticated curare plants, *Chondodendron tomentosum*. *d*-TUBOCURARINE CHLORIDE SOLUTION-CUTTER is pure by chemical analysis, standardized by weight and contains 20 units (3.0 mgm.) per cc. of the crystalline pentahydrate in sterile isotonic solution with 0.5% Chlorobutanol. Available in 10 cc. Safticel vials—stable at room temperature.

d-TUBOCURARINE CHLORIDE SOLUTION-

CUTTER
BERKELEY • CALIFORNIA

How will the ownership of a unit affect my attitude toward the full use of X-ray techniques? The doctor with X-ray apparatus in his office relies upon it increasingly to confirm or to amplify his diagnoses. Such has been my experience.

But I have tried to retain a realistic humility with regard to my own skill in this specialty. There are certain types of X-ray examination that I do not make myself. When there is any doubt in my mind about the interpretation of a film, I refer the case to a radiologist. Here is a typical instance:

The patient was a 34-year-old former G.I., now working for a Chicago newspaper. He came to my office and complained of blood in his sputum. He had no other significant symptoms or complaints. He had begun to spit blood about six months before consulting me. At that time he had gone to another doctor, and his case was diagnosed as rupturing of capillary blood vessels in his pharynx. His symptoms diappeared and he was not bothered again until a few days before he came to my office.

A complete physical examination revealed nothing of significance. A chest radiograph was made, and there appeared a lesion in the left apex. His sputum was sent to the hospital for pathological findings, which were returned as negative. Nevertheless, the patient was sent to a radiologist because of the rather obscure lesion in the chest. The radiologist diagnosed the case as an infiltrating lesion involving the parenchyma of the apical portion of the left lung. "This lesion," said the report, "is a fibrotic tuberculosis of short standing."

The specialist might never have seen this case but for my preliminary X-ray examination. Such situations arise so often that I now refer many more cases to radiologists than I did before installing an X-ray unit.

What effect will the installation of X-ray equipment have on the attitude of my patients? I've noticed a growing tendency on the part of the layman to expect his doctor to have X-ray facilities. Patients who know I have the equipment frequently ask for X-ray examination. Even new patients who don't know about my equipment often suggest it.

No patient has demurred when X-ray examination was suggested. Quite the contrary. When patients such as those with stomach disorders request immediate X-ray examination, I advise waiting to see whether the condition responds to simple medicinal treatment. Thus they may be able to avoid the added expense.

Sometimes the use of X-ray for diagnostic purposes has a powerful psychological effect. For example, in the treatment of cardiac decompensation with pulmonary edema, I make radiographs once a week for six weeks and then once every six months, to observe the progress of the treatment. Showing the patient

b FOR BALANCED

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BALANCED Psychologically . . . by imparting immediately a sense of cool, clean, gratifying comfort, Tyree's restores the woman patient's subjective balance and makes her amenable to further curative treatment.

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BALANCED Therapeutically . . . finally, Tyree's value as a vaginal douche is positive, because it balances *effectiveness* with *safety*, avoids complications caused by caustic, irritating douching, while it acts as an effective treatment in vaginal infection. Try Tyree's the next time you prescribe a vaginal douche. Write for literature and professional samples.

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for the treatment of genito-urinary infections

visual evidence of his improved condition probably contributes as much as any other factor toward his improvement.

To sum up, my experience with X-ray has been satisfactory from every point of view. The operation of the equipment has brought me few technical difficulties. An easily read technique chart, furnished by the manufacturer, provides correct exposure factors. The only other technical manual I have used is the U.S. Army's "Military Roentgenology."

A final word about equipment. The doctor who considers the purchase of an X-ray unit is likely to be confused and puzzled, as I was, by the variety of machines available. What should his unit do?

My first inclination was to purchase a vertical fluoroscope. With no provision for radiography, however, I realized that the type of work I could do would be limited. So I bought a combination radiographic and fluoroscopic unit. Mine happens to be an upright. For horizontal radiography I use a wooden examining table in conjunction with my unit. (Now on the market are units that may be used for both fluoroscopy and radiography, with the patient in either the upright or horizontal position. These units embody an X-ray table that may be used also as an examining table.)

My present unit is rated at 20 milliamperes, 80,000 volts. For the work I've wanted to do, this machine has been eminently satisfactory. It is not suitable for spot film radiography, certain types of gastrointestinal examinations, or examinations that are normally hospital procedures. But I don't intend to do this type of work. Such examinations should, in my opinion, be made under the direct supervision of a radiologist.

You may be tempted to purchase a unit in the 30 to 60 MA class, assuming that the more powerful unit will produce better results. I disagree. Units of these intermediate power ratings are no more suitable than the 20 MA machines for the special examinations mentioned. And they are actually less suitable for the type of work the average doctor wants to do in his office. As the MA rating increases, the focal spot in the tube becomes larger. Tubes with larger focal spots produce films in which the detail is not so good. Finally, the higher cost of the more powerful units may well turn out to be a needless expense for the average doctor.

—WILLIAM F. P. PHILLIPS, M.D.

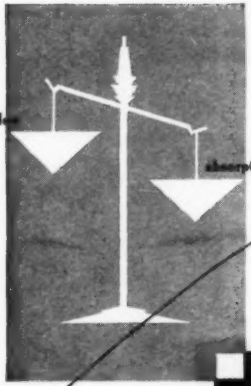
* HANDITIP *

Mirror Magic

If you have a small, dark waiting room, try putting an outsize mirror on the wall opposite the window. You'll be surprised how it brightens the room and makes it seem larger.

—M.D., MARYLAND

* * * * *



so adequate

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*Am. J. Obst. & Gyn., 31:979, 1936.

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How the Wagner Plan Would Work

Part 1 of a series takes up the quality of medical care that would result

• Senate Bill 5, which maps out a system of tax-financed medical care for this country, contains eighty-four pages and some 15,000 words. Yet nowhere does it come to grips with a question of prime importance to every patient: "What kind of medical care would I get under the plan?"

The subject of quality is dealt with in six passing mentions. One of the bill's eight purposes, for example, is "to provide adequate health services consistent with the highest standards of quality." In describing the payment of physicians, the bill says: "Such payments shall be adequate to encourage high standards in the quality of services furnished." A little further along, the bill authorizes a ceiling on the number of patients served by one doctor "in order to maintain high standards in the quality of services furnished."

These are, of course, estimable goals. What the patient wants to know is: Can they be attained?

To find out, let's take a close look at how the Wagner plan would work. Its backbone, according to nearly all the experts who have testified during Congressional health hearings, would be a system of panel medicine. How would this arrangement affect quality?

Prognosis Poor

From all the available evidence, the Wagner plan would lower the quality of medical care. It would do this for three main reasons: (1) less time spent per patient; (2) Goverment red tape; (3) the attitude of the physician.

Almost everyone concedes that compulsory health insurance would bring an immediate, sharp boost in the average M.D.'s patient load. Knowing they were entitled to "free" medical care whenever they wanted it, many people would visit

---

**This article is the first of several that will present a point-by-point evaluation of S. 5 and H.R. 783, the current Wagner-Murray-Dingell bills. Later articles will discuss the cost of compulsory health insurance, the benefits available, administration, free choice, etc.*

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the doctor oftener. With no prospect of altering the basic doctor-patient ratio in the immediate future, the end result could only be less time spent per patient.

It's significant that the English physician, under socialized medicine, spends less than half as much time per patient as the average American doctor; yet the doctor-patient ratios of the two countries are roughly comparable. An enforced speed-up of this magnitude could hardly be expected to produce Grade A medical care.

Then there's the matter of red tape. No Government scheme on the Wagnerian scale has yet been devised without a heavy accompaniment of rules and directives. Under the Wagner bill, most of them would be written by a five-man Federal board. It is specifically empowered to issue any regulations needed to operate the program.

How this would affect patients is suggested by a number of restrictions already in the bill. No patient could see a specialist, for example, without first having his visit certified as necessary by his panel G.P.—or, on appeal, by an "administrative medical officer."

Finally, consider the attitude of the panel physician. His prime responsibility would not be to the patient, as now, but to the Government—since he'd be on the Government payroll. An impersonal sort of mass medicine would almost surely result.

Note, for instance, the verdict

arrived at by Walter Sulzbach, University of Frankfort sociologist, after years of studying Germany's brand of compulsory health insurance. Says Sulzbach: "Patients of the German health insurance plan were rarely satisfied with the medical care they received. It was a system of mass treatment in which many doctors spent only a few minutes on each visitor during office hours and made home visits as short as possible. Since payment was on a per capita basis, the overworked doctor reduced not the number of his patients, but the time spent with each."

In this country, the man who's probably had the most experience with "mass medicine" is Dr. Paul R. Hawley. Here, to top things off, is his evaluation of the Wagner plan: "It will inevitably lower the quality of medical practice. This will be a thousand times worse for our people than a distribution of medical care that may not be all we want it to be." —ALTON S. COLE

Rx Refills to Be Controlled

Government to bar druggists from refilling prescriptions without the doctor's okay

• Prescription-writing habits of long standing may soon undergo important changes under the impact of the Food and Drug Administration's control of pharmacists' refilling practices. During the transition period, a number of problems may arise involving the physician-pharmacist-patient relationship. However, though the F&DA's control does not extend to doctors, potential irritations can be minimized if medical men understand the new concept of prescription refilling that the Federal Government is preparing to enforce.

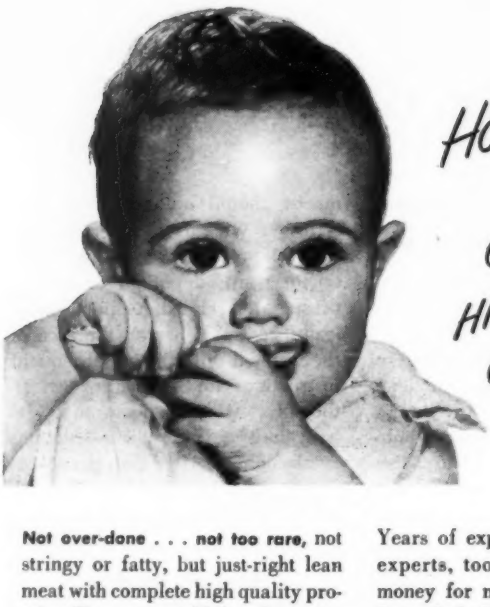
It has long been customary for pharmacists in many areas to regard the absence of any reference to refills on a prescription order as the signal to refill the prescription as many times as the patient requests. Now the F&DA wants pharmacists to regard the absence of refill instructions as a signal that the prescription is *not* to be refilled—unless the doctor provides additional instructions.

The F&DA's view is that a pharmacist should not refill *any* prescription without the specific authorization of the physician. If the doctor wants a patient to have a prescription refilled, he must specifically say so—either on the face of the original order or in subsequent instructions to the pharmacist. In the latter event, the doctor may verbally indicate his refill instructions to the pharmacist. But the pharmacist may, in some instances, ask the doctor for written confirmation of such instructions.

Doctor's Orders

Some physicians have been using variations of the Latin "Non Rep." to indicate that they do not want certain prescriptions refilled. The practice of indicating a specific number of refills also prevails in many localities. But, in the absence of such notations, many pharmacists have made it a practice to refill ad lib.

F&DA authorities believe that indiscriminate refilling results in a deterioration of the special legal and professional status of a prescription. As they see it, a prescription is "a written expression of the physician's will and purpose that the individual patient for whom he is prescribing be fur-



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nished a specific quantity of a drug for use by that patient under the physician's direction and supervision." They have turned up cases where ad lib refilling has continued for many years after the patient received the original prescription order. In many instances, refills have been passed along to friends and relatives of the patient.

Here's the way Food and Drugs Commissioner P. B. Dunbar states the position of his agency:

"If it is the physician's will and purpose that the prescription be refilled, as expressed by his written notation on the prescription or by oral communication, confirmed later in writing, refilling is entirely proper. But to refill a prescription without such assurance . . . is in logic and in fact not distinguishable from an over-the-counter sale of the drug."

The F&DA anticipates that its new program on refilling prescriptions may cause controversy—particularly among physicians who may regard specific refilling instructions as an unnecessary bother. But the F&DA feels that it must take this position on *all* drugs to assure effective control over the dispensing of harmful drugs.

To support its view that Rx refilling practices should be revised, the agency cites cases like the one uncovered in December 1946, in North Kansas City.

Investigating the death of a

"If he gives ya any trouble, Joey, just give that stetascope thing a rap after he plugs it in his ears."

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Rheumatoid Foot and Leg Pains . . .

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Excessive Fatigue due to Foot Strain and Weak Arch

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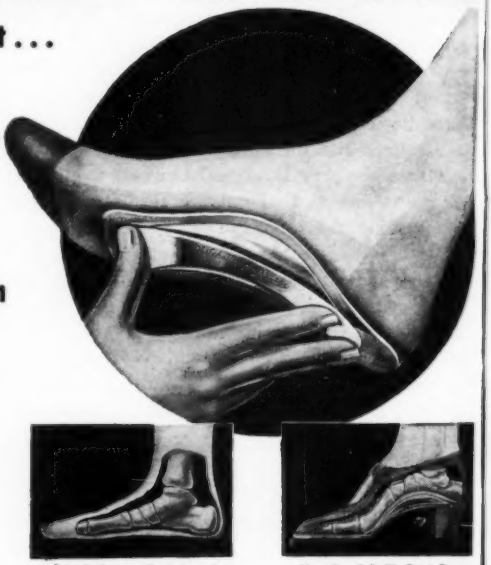

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woman, local police and F&DA inspectors found that she had been regularly taking barbiturates. They traced the source to a Hollywood, Calif., druggist, and indicted him.

At the trial, it developed that five years before her death the woman had lived in San Diego, and had there consulted a doctor. He had written two prescriptions for barbiturates. Both had been filled and refilled by the Hollywood druggist. After the woman moved to North Kansas City, he continued to refill her prescriptions by mail—each time stepping up the number of capsules per refill. One prescription, originally written for a mere ten capsules, had been refilled fifty times in five years, for a total of more than 6,000 capsules. The other prescription, written for fifteen capsules, had been refilled forty-three times, for more than 7,000 capsules.

Of course, this is an extreme case. But the F&DA believes it has enough cases in its files to warrant a change in refilling customs. To make the reform effective, the agency realizes it must have the cooperation of physicians, who must be willing to write precise refill instructions on the original prescription blank if they want patients to use the Rx over again.

F&DA men believe there are many instances in which multiple refills may be justified. But they want to leave the responsibility for determining these cases, and the number of refills, up to the physician. Even in cases where prolonged use of the same medication is indicated, the F&DA believes the prescription should have some definite termination date.

Some states already have laws or regulations limiting the refilling of prescriptions for potent drugs. But the F&DA feels that a national approach to the problem is necessary to insure uniformity of enforcement and maximum public protection. Federal officials say, however, they don't want the job of policing all the retail pharmacies in the country. Therefore, they will welcome all efforts on the part of state and local authorities to cooperate with the new program.

Though the present Federal Food, Drug, and Cosmetic law has been in effect for over ten years, it was only lately that the F&DA received assurance of its control authority over the sale of drugs at retail. Judicial doubt on this was eliminated by a recent decision of the Supreme Court, and by Congress' subsequent amendment of the law to conform with the court's endorsement.

Though armed with increased authority, the F&DA doesn't plan to start a nationwide enforcement campaign overnight. It hopes to accomplish most of its objective by educating doctors and pharmacists on its new position with regard to refilling. For a while, at least, enforcement will be used only in instances of flagrant violation of the law.

—WALLACE WERBLE


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For the Relief of
MUSCULAR ACHES
AND PAINS...
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A Check-List of Insurance Terms

Part 3 of a series that should help you keep tabs on your insurance coverage

• PERSONAL PROPERTY FLOATER. A policy that protects personal property against nearly all risks, regardless of location at the time of the loss. A specified deduction (often $25) is sometimes subtracted from any settlement.

PREFERRED RISK POLICY. Life insurance available at lower-than-average premiums to applicants who are better-than-average risks.

RATING-UP. A method by which insurance companies deal with substandard life insurance risks. Applicants in this category are charged an extra premium or issued a policy computed for an age higher than their actual age.

REINSURANCE. A method by which an insurance company may farm out part of a risk that is larger than it wishes to carry. The company itself thus buys insurance.

RENEWABLE POLICY. A policy that the holder has a right to renew at the end of its term, simply by payment of a stipulated premium. Most life insurance policies are renewable; most other types are not.

RENTAL VALUE INSURANCE. A type of fire insurance that protects the holder against rental expense while the insured property is being rebuilt after a casualty loss.

SHORT RATE PREMIUM. The premium rate that applies when a policy holder cancels his fire or similar insurance policy before the end of its term. It is computed at a higher rate than normal to cover the company's expense in writing the policy.

SUBROGATION. A policy provision giving the insurance company the right to recover, from the person responsible for the loss, the amount it pays out under the policy.

SURRENDER CHARGE. The deduction that a company makes from the premium reserve of a level-premium life insurance policy in computing the policy's cash surrender

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**Bion H. Francis, author of this series of definitions, is an insurance consultant licensed in Massachusetts. He has written, either alone or in collaboration with others, such books as "Life Insurance from the Buyer's Point of View" and "How to Start a Life Insurance Program."*

value. The surrender charge is intended to reimburse the company for the cost of writing the policy if it's discontinued after only a short time in force.

SURVIVORSHIP ANNUITY. An annuity that provides an income for another person after the death of the policy holder. Sometimes a

lapse of several years is stipulated before income payments to the survivor begin.

TERM INSURANCE. A life insurance policy written for a limited period (but often renewable) and having no cash value at the end of its term.

TWISTING. The efforts of a life insurance agent to induce a policy holder to drop one company's policy in favor of another's, merely to provide a commission for the agent. Twisting is illegal in many states.

VALUED POLICY. A policy that states the exact amount to be paid in the event of total loss.

WAIVER OF PREMIUM. A valuable provision added to life insurance policies for an extra charge. It states

that further premium payments will be dispensed with if the policy holder becomes totally and permanently disabled. —BION H. FRANCIS

What They're Reading

ARTICLES

HEALTH IS ITS BUSINESS. By Maxine Davis. What it's like to live in Rochester, Minn., as a neighbor of the Mayo Clinic. Holiday, February.

WE CAN MAKE CHILDBIRTH SAFER. By J. D. Ratcliff. How the New York Academy of Medicine's Committee on Maternal Welfare checks on all maternal deaths in Manhattan. Ladies' Home Journal, February.

BOOKLETS

VOLUNTARY PREPAYMENT MEDICAL CARE PLANS, 1948. Compiled by the AMA Council on Medical Service. This revised edition contains descriptions of new as well as old prepayment plans. Included are details on type of contract, income limits, benefits, premiums, etc. American Medical Association, Chicago. Gratis.

BOOKS

MORE THAN ARMIES. By Booth Mooney. Life story of Dr. Edward H. Cary, prime mover of the National Physicians Committee. 270 pp. Mathis, Van Nort & Co., Dallas. $5.

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The Blue Cross National Set-Up

It's being pushed steadily, but won't begin operations much before next spring

• In about a year or so, you may begin to notice a marked bulge in the number of your patients covered by hospitalization insurance. That's the Blue Cross target date for getting its new national insurance company okayed by insurance commissioners of the big industrial states. Through this medium, Blue Cross hopes to sign up substantial numbers of the national accounts that have hitherto eluded both Blue Cross and Blue Shield.

The medical care plans are not participating directly in this experiment. The AMA House of Delegates turned a cold shoulder to the idea last December. But that won't keep doctors from following its progress with special interest; they are well aware that voluntary hospitalization insurance has long been the bellwether in the fight against state medicine. And if the new scheme works, the medical plans may yet follow suit.

Aim of the Blue Cross project is to meet the demands of large national firms that want single-contract, multi-state coverage for their employes. The project is slowly beginning to take shape:

A nonprofit holding company, the Blue Cross Association, has already been formed to raise the necessary funds from local plans. This money will be used to set up a Blue Cross stock insurance company. A minimum of $375,000 is needed. Blue Cross officials expect contributions to reach that figure sometime this month.

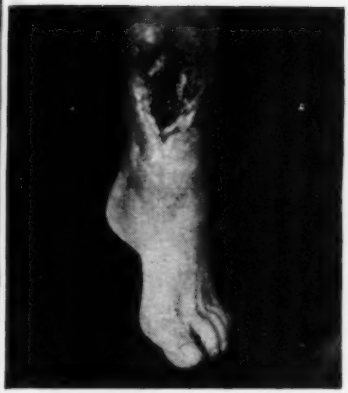
Blueprint for Action

Main functions of the Blue Cross national insurance company will be threefold:

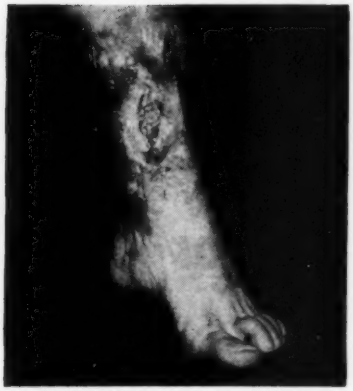
¶ It will solicit national accounts, drawing up a uniform-premium, uniform-benefit contract to suit the requirements of each.

¶ It will underwrite supplemental hospital benefits where the local Blue Cross plan is unable or unwilling to offer the full benefits called for in the national contract.

¶ It will handle all billing of and collections from national accounts, passing on to each local plan that portion of premium receipts applying to benefits underwritten by that plan. (Hospitals will continue to bill and collect from local Blue Cross plans.) [*Continued on* 121]



Chronic osteomyelitis of *12 years' duration.* 14 surgical procedures failed to close the cavity. Pain and foul-smelling discharge caused patient to request amputation.



Treatment with Chloresium brought progressive closure of the cavity. Purulent drainage and odor stopped. Pinch grafts were successful and cavity closed completely.

CHLOROPHYLL HEALED

where other methods of treatment failed

• The case shown above is one of hundreds which resisted other methods of treatment—until Chloresium therapeutic chlorophyll preparations were used. The published record* shows that the majority of them not only *responded rapidly* to Chloresium's chlorophyll therapy, but *healed completely* in a relatively short time.

Results with Chloresium in acute cases have been equally dramatic. Faster healing, less infection, less scar tissue formation and quick deodorization of foul-smelling conditions have been obtained.

This new approach to prompt, effective healing is due to Chloresium's proved ability to stimulate normal cell growth. Try it on your most resistant case—it is completely nontoxic, bland and soothing.

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Solution (Plain); Ointment; Nasal and Aerosol Solutions

Ethically promoted—at leading drugstores

*Boehme, E. J.	The Treatment of Chronic Leg Ulcers	The Labey Clinic Bulletin, 4:242 (1946)
Bowers, Warner F.	Chlorophyll in Wound Healing and Suppurative Disease	Amer. J. Surgery, LXXIII:37 (1947)
Cady, Jos. B. Morgan, W. S.	Treatment of Chronic Ulcers with Chlorophyll	Amer. J. Surgery, LXXV:4 (1948)
Johnson, Harold M.	Dermatologic evaluation...	Arch. Dermat. & Syph. 57:348 (1948)
Langley, W. D. Morgan, W. S.	Chlorophyll in the Treatment of Dermatoses	Penn. Med. Journal, Vol. 51: No. 1 (1948)

NEW—Chloresium Dental Ointment and Tooth Paste now make chlorophyll therapy available for the treatment of Vincent's infections, gingivitis and other periodontal diseases.

FREE—CLINICAL SAMPLES

RYSTAN CO., INC. Dept. ME-2
7 N. MacQuesten Pkwy., Mt. Vernon, N. Y.
I want to try Chloresium on my most resistant case. Please send me, without obligation, clinical samples and complete literature.

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Know Your ACES, Doctor

The importance of using the correct bandage in treating specific conditions is self-evident . . . important enough for B-D to provide two distinct ACE BANDAGES.

ACE® COTTON (NO. 1)

All Cotton Elastic

Universally accepted, as the original cotton elastic bandage, in the management of varicose veins and ulcers, strains, sprains and various muscular injuries. Unique weave provides maximum elasticity without rubber.

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Increasingly employed because its prolonged support is ideal for surgical use, where occlusive pressure bandaging is required . . . also for weak knees and ankles, muscle rupture, and as a general supportive bandage.

ACE BANDAGES *are cool, comfortable, long-lasting and washable.*

●

Remember . . . "Only B-D makes ACE Elastic Bandages."

BECTON, DICKINSON & CO., RUTHERFORD, N. J.

The Blue Cross Commission has listed some 11,000 national accounts (business firms, large unions, etc.) that are ripe prospects for prepaid hospitalization. It is these accounts that the Blue Cross insurance company will start gunning for as soon as state insurance commissioners give it the green light. A membership jump of some 8 million within eighteen months is anticipated.

The new unit may also play a part in boosting medical care plan enrollment. It may act as a national enrollment agency for Blue Shield where the subscribing firm wants medical insurance along with the hospitalization. The Blue Cross company will even be empowered to write "gap coverage" on local medical care plans. It may do so, according to present feeling, if the demand from national accounts is sufficient. —T. K. BROOKS

At Doctor's

[*Cont. from* 83]

the good doctor had gone all out to reduce the tedium of waiting. Near me sat a large-bosomed lady, carving a moose out of a bar of soap. "My gall bladder defies medical science!" she shouted across to a bouncy little man who was whipping the sox off his opponent at ping-pong.

I eased into a chair on the sidelines, wishing I had brought my golf clubs. Behind me I became aware of a voice saying, "Look, if you hadn't been so busy describing your polyps, you would have remembered to finesse that jack."

I craned my neck to locate the bridge game. As I did so, I noticed two small boys using electric appliances to burn hearts and initials on leather.

"Florence starts with Ph, not F," one boy argued.

I was about to set them straight on the spelling of Phlorence when a nurse poked her nose in the door.

"You wish to see the doctor?" she asked me.

The odor of burning leather had begun to upset my stomach. "I didn't come here to raffle off a turkey," I snapped.

"A turkey!" she jumped up and down, clapping her hands. "Doctor, come quick!"

Dr. Witherspoon rushed out of his consultation room. "Yes," he chortled, rubbing his hands together, "I heard. Bully idea! Call the Chick Poultry Company. Order a hundred turkeys. We can raffle them off from two to five each Tuesday."

Closing in, the patients formed a conga line. They danced around him, cheering lustily.

By the time the excitement subsided, it was getting late. Dr. Witherspoon decided to close the office for the day so we could all go home and come back Tuesday for a fresh start. Remembering that it had been my idea, he promised that I could raffle off the first turkey. —M. M. PORTERFIELD

Deadline Near on Doctor Draft

Community campaign offers last chance to fill need through voluntary enlistments

• Those who want to know whether doctors will be drafted are soon due for a straight answer. The news will probably come at the end of this month, when the Defense Secretary's Medical Advisory Committee adds up the results of its recently launched community campaign for recruiting volunteers. If the new campaign seems to be producing its quota of M.D.'s, chances for a doctor draft in 1949 are slim. If the drive is a dud, a draft may be the only alternative.

The armed forces say they must have 1,600 more physicians by midsummer, a total of 2,200 more by December. The AMA accepts these figures and is cooperating fully in an effort to muster volunteers. This cooperation is due in part to the association's feeling that the new Medical Advisory Committee gives the profession an authoritative voice at high policy levels. Heading this committee is Charles P. Cooper, president of New York's Presbyterian Hospital. Other members include Dr. Edward Churchill of Massachusetts General Hospital; Dr. Paul R. Hawley, executive director of Blue Cross and Blue Shield; and Dr. Howard A. Rusk of New York University.

The community campaign on which the committee is counting to avoid a doctor draft is aimed primarily at 8,000 ASTP's and V-12's trained at Government expense. It also hits some 7,000 other young doctors who didn't see combat service because they were deferred to continue their medical studies at their own expense. Both groups are being told it is their moral obligation to volunteer. Says a spokesman for the Medical Advisory Committee: "We feel that if we can reach and translate our critical need to these men, we will get enough of them to meet our quota."

The Finger Points

In a letter mailed to 9,000 doctors under the age of 26, AMA President Roscoe L. Sensenich said: "The United States must depend on the young physicians who were educated during the war, and who have had little or no active military duty, to volunteer in this time of need. Thousands of older physicians served voluntarily during the war and the responsibility now

rests on the young men to continue the medical profession's record of service."

The community campaign is set up to function through professional manpower committees, established as local subcommittees to the military manpower groups already active in recruiting work. The professional committees are staffed by local physicians. The Secretary of Defense supplies them with names of local ASTP and V-12 graduates, whom they proceed to contact personally.

To encourage volunteers, the Medical Advisory Committee promises that inductions will be arranged with minimum disruption of interneships and residencies. Volunteers are permitted to finish their present periods of hospital training. Many ASTP's go in as captains with two years' service credit. In addition to Army base pay, they receive the extra $100 a month voted last year by Congress for doctors who volunteer. As further inducement, Congress is currently considering a new pay boost that would hike the base pay for captains with two years' service to $330 a month.

The Medical Advisory Committee has given no sign that it considers failure even a remote possibility. The question that remains unanswered—at least until the end of this month—is whether its campaign of moral suasion is strong enough to surmount the characteristically human attitude of "Let George do it." —NELSON ADAMS

titled to a good ranting session, invoking Army Regulations and the Articles of War. But now that A.R.'s have been amended, the C.O. merely revises the padre's statement to read, "Good *soldiers* don't get VD."

As the star of the bill, the medical officer winds up the show. He refines and enlarges on the C.O.'s and the chaplain's remarks. But individual medical officers have radically different ways of delivering their message.

Doctor Takes Over

For example, there's the Scientist-Doctor. He gets every tenth man to stand up, then explains that this number can expect to get lues. He describes the gram-negative, coffee-bean-shaped diplococci and the *Treponema pallidum*. The audience mentally follows him in and out of laboratories, clinics, and hospitals. The men get a scientific education. Weeks later, instead of alluding vaguely to a sore on the privates, many of them are able, quite correctly, to report a chancre.

Another approach is that of the Preacher-Doctor. This is a dramatic role in the hellfire-and-damnation tradition. The spirochete is portrayed as a slimy dragon, gnawing away at the heart and brain. The talk is enlivened with examples of the innocent afflicted: a once-lovely creature of pure womanhood, her beauty gone, begging and blind; a pink babe in arms, covered with loathesome sores; finally, the instigator of it all, babbling away his final hours in an insane asylum.

At the end of the talk a silent pall hangs over the audience. Then, after the appropriate incubation period, and with proper anguish, the soldier confesses he has acquired VD.

There's the Comic-Doctor, too. Often he draws a larger crowd than a onetime USO show. His humor is attuned to the mental age of those who read their comic books aloud.

The medic recounts the various entertaining ways VD can be acquired. The synonyms that different strata of society have for the venereal diseases are always good for laughs. At the finish there is a great round of applause. In the same spirit of fun, a man reporting on sick call later can blandly announce he has a "strain."

Command Performance

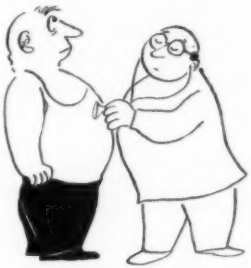
As a commentary on the effectiveness of all this prophylactic oratory, the Army provides for short-arm inspections at regular intervals. These are carried out with the planning and finesse of a Commando raid. Someone in higher echelons has deduced that if a man has VD, he has it even more at 3 A.M. At that hour a crew consisting of medical officer, company officer, and sergeant swoop down upon the barracks.

The lights go on. The chorus of snores becomes a chorus of yawns and ill-disguised profanity. The

doctor goes down the line with his flashlight centered on the subumbilical region. He reaps a harvest of names for the VD clinic where, next morning, each suspected G.I. is processed and pronounced.

If he has "it," an attempt is made to find the contact. First he's asked, as one citizen to another, to do his duty. Then he is threatened or cajoled, as his personality requires. Usually the contact is then identified as "Bubbles," who resides around the corner from Jim's Bar and Grill (or was it Joe's?).

Under Army Regulations, physical examination is also required of WAC's. In the beginning, this posed a nice problem. After several conferences it was decided that examination would consist of inspection of the palm and dorsum of the



1.

2.

3.

4.

Forty... Fat, and— Fair Treatment

It has been said that the gallbladder is seldom anatomically normal in middle age; and also that the woman over 40 is apt to attribute any complaint to either the menopause or her gallbladder. There is perhaps some justification for the latter lay-diagnosis, since bile tract abnormality is 2½ to 3 times as common in women as in men.

Treatment based on physiological principles, it has been shown, will improve three out of four cases. The well-known, simple regime is based on these essentials:

1 Gallbladder emptying is stimulated by fat, especially uncooked fat such as butter and cream.

2 Utilization of the fat is aided by giving Doxychol-K*; its desoxycholic acid content is noted for efficient transport of fatty compounds across the intestinal mucosa.

3 Doxychol-K also markedly increases the flow of hepatic bile to further improve drainage of the biliary tract.

*Trademark of George A. Breon & Co.

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hands. Presumably, when a pair of sweaty palms is exposed, the medical officer may cough sympathetically.

Next to forms completed in quintuplicate, the Army is fondest of statistical analyses. VD lends itself admirably to both. It is a daily, weekly, monthly, yearly job. The local VD officer holds conferences with company officers, the regional officers with the local, and the national officers with the regional. At each conference, an analysis of the statistics is presented. A VD officer may then with propriety sob over the fact that the rate has increased 0.05 per cent.

As with statistics anywhere, anything can be proved. The medical officer always faces a dilemma: Should he report a falling rate (and be praised for a good job) or a rising rate (demonstrating the need of more personnel and/or higher rank)?

In the early days of the war, acquiring VD was considered a breach of discipline. But this occasionally raised knotty problems. For instance, if a man with VD denied having had relations with anyone except his wife, wasn't his contraction of the disease actually "in line of duty"?

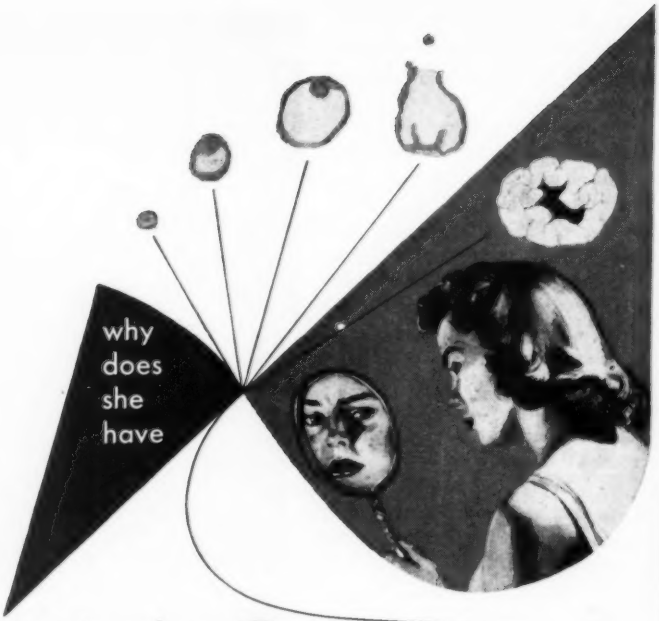
For a while, too, venereal disease was sufficient reason for not sending a man overseas. The good word spread rapidly. Once, during a physical examination just prior to overseas shipment, an entire company was found to have a thick,

creamy urethral discharge. But the very copiousness of the discharge proved suspicious. It turned out to be evaporated milk.

The Army's VD program cannot be called a failure, judging from wartime attendance at prophylactic stations. Probably the record for promptness belongs to one soldier who appeared less than three minutes after exposure. The epitome of conscientiousness was Snafu, the Army comic-strip character, who had a pro after a nocturnal emission.

Wherever there are soldiers, there are pro stations—even on transport ships. The story goes that, on one such ship, five nurses were being returned to the States. Every day during the voyage, one soldier reported for a pro. Speculation was rife as to who among the nurses was "it." After a while, even the nurses wouldn't speak to each other. The practical joker wound up with a chemical urethritis, but very smug.

—THEODORE KAMHOLTZ, M.D.



Periodic Acne?

The ovaries appear to exert a definite but variable influence on the condition of the skin. The effect is upon the sebaceous glands, primarily, and a disturbance in this ovarian-dermol relationship seems to be responsible for "periodic acne." This skin eruption comes and goes with the menstrual cycle. This condition may also be accompanied by periodic headaches.

Ovarian Concentrate Armour

has proved quite beneficial in this syndrome. It's a special sterol fraction, free from demonstrable estrogenic properties, derived from the fat and lipoid fraction of whole ovaries by a special process originated in The Armour Laboratories.

DOSAGE: For periodic acne—one glanule t.i.d. with meals for one month. Then, one glanule t.i.d. for 7 to 10 days premenstrually may suffice.

Have confidence in the preparation you prescribe — specify "Armour"

ARMOUR *Laboratories*

HEADQUARTERS FOR MEDICINALS OF ANIMAL ORIGIN • CHICAGO 9, ILLINOIS

AMA Drive [*Cont. from* 64]

cooler view, however, is expressed by one AMA officer: "The important thing is that these men are opposed to compulsory health insurance. As for disagreeing with the association's approach, every member is entitled to do that. If they can suggest better ways of doing what we're trying to do, we'll welcome their ideas."

Problems like these may hold up the longer-range, public-education phase of the campaign for some time. But even die-hard skeptics admit that the AMA scored an important gain with its twelve-point legislative platform. This would:

1. Create a Federal Department of Health, with an M.D. as its secretary.
2. Establish a National Science Foundation.
3. Provide grants-in-aid for states to enroll indigents in voluntary prepay plans.
4. Set up a joint doctor-layman authority in each state to receive and spend Federal funds.
5. Expand the Hill-Burton Hospital Construction Act.
6. Create public health units in areas now lacking them.
7. Develop a new mental hygiene program, with grants-in-aid to clinics.
8. Stimulate health education.
9. Provide facilities for care of the chronically ill and the aged.
10. Integrate V.A. medical functions with other Government programs and privately-run plans.
11. Emphasize industrial medicine and accident prevention.
12. Provide Federal aid for medical education, free from political control.

This platform, together with the W & B plan, have "pleasantly surprised" many state society public relations officers. Most seem ready to accept at face value Clem Whitaker's blunt prophecy: "This will be no pantywaist campaign."

And it isn't. The twelve-point program attracted not only some bouquets but also the usual assortment of brickbats. Said The Detroit Free Press, an opponent of the W-M-D bill: "We have read [the twelve-point program] and find it nothing but cheap platitudes and demagogic weasel words . . . Do the leaders of American medicine really expect the American people to fall for such flapdoodle?" Front-paged The New York Times: "DECEIT LAID TO AMA ON INSURING HEALTH." And a syndicated columnist described the program as being akin to "the AMA's deathbed conversion."

Medicine is still on the defensive. Converting this rear-guard action into a spirited, constructive, frontal attack is basic to W & B plans. American doctors, says Whitaker, are going to "expose the shameful misrepresentation and the deliberate attempt to hide from the people the cost and social consequences" of the Truman-Ewing program. This month many a home-

town physician will buckle down to the task. —EDMUND R. BECKWITH JR.

[What follows is the full text of the protest issued by 148 medical leaders, plus the AMA trustees' reply.]

PROTEST TO THE AMA

Numerous comments by medical colleagues in various parts of the country have convinced the undersigned physicians that a large segment of the medical profession is not in sympathy with many policies and actions of the American Medi-

Edwards A. Park

cal Association on the extension of medical care. The $25 assessment levied in executive session upon all members of the association will place several million dollars at the disposal of its officials. Only an indefinite and constructively inadequate program has been presented outlining the way in which this huge fund will be used. The charge to association officials is exceedingly vague, leaving the methods to be employed at their discretion and subject to the possibility of grave abuse.

If the funds are to be used for propaganda and legislative lobbying instead of developing a comprehensive medical care program, we are heartily opposed to the levy and shall refuse to pay it, and we urge all physicians with a sense of responsibility for the future of American medicine to register their protest. The significance of standpat propaganda will not escape the public. This will add to the already firmly rooted suspicion that the association's objectives are primarily economic and selfish and will further weaken its standing as an altruistic agency devoted to the improvement of medical practice, research, and education. We would gladly contribute if the funds were to be used to develop a carefully worked out, comprehensive plan to extend and improve medical care and education.

George Baehr

We believe that the fundamental failure of the AMA in its attitudes

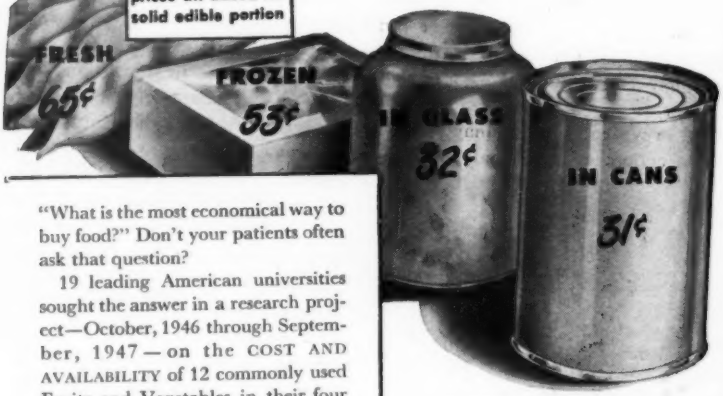
Hugh J. Morgan

RESEARCH SHOWS HOW YOUR PATIENTS CAN HAVE GOOD FOOD AT LESS COST

EXAMPLE: LIMA BEANS PER PENNY

Following average prices all based on solid edible portion

Full-year field check by 19 Universities* provides significant data on meeting today's living costs.



"What is the most economical way to buy food?" Don't your patients often ask that question?

19 leading American universities sought the answer in a research project—October, 1946 through September, 1947—on the COST AND AVAILABILITY of 12 commonly used Fruits and Vegetables in their four regularly marketed forms . . . FRESH, FROZEN, in GLASS, and in CANS.

The results of this comprehensive study boil down to this: *Penny for penny, canned foods in general give consumers more food for their money, as well as more nutritional values. Most foods in cans cost less than the same foods in glass—less than fresh foods—and far less than frozen foods.*

FREE booklet giving full details of Comparative Cost and Availability Study. Copies of previously published booklet, "Canned Foods in the Nutritional Spotlight," are also available.

Please send me, free of charge, ... M copies of the new booklet entitled: "Canned Foods in the Economic Spotlight."

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☐ Also send . . . . . copies of "Canned Foods in the Nutritional Spotlight."

SOUND RECOMMENDATION

We are confident that the more closely you study the known nutritional values of foods in cans, their *high* percentage of year-round availability, and their *low* cost generally, the more justified will you feel in recommending this solution to today's high cost of living.

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**For full details see "Comparative Cost and Availability of Canned, Glassed, Frozen, and Fresh Fruits and Vegetables" in the April, 1948 issue of the Journal of the American Dietetic Association.*

and policies bearing on the general problem of medical care has been its unwillingness fully to acknowledge the need for improvement and to seize this particularly favorable opportunity to come forward with a comprehensive, constructive program which would be of clear advantage to the public as well as to the profession itself. Further, we believe that in the present crisis the obvious direct way to avoid an all-inclusive compulsory health insurance and to make secure the valuable features of our present system is for the association to develop a program that will be manifestly so considerate of the needs of the people and at the same time so eminently fair to the interests of the physicians that it will command general approbation.

[Among the 148 signers of the above statement were: Drs. M. E. Lapham, Chester S. Keefer, Allen O. Whipple, A. B. Sabin, R. V. Platou, Alton Ochsner, W. Barry Wood, James Howard Means, S. Bernard Wortis, Currier McEwen, Henry M. Helmholz, Harold Lillie, Helen B. Taussig, William S. Ladd, Hugh Morgan, I. S. Ravdin, Wilburt C. Davison, Edwards A. Park, George Baehr, George Whipple, Ernest A. Goodpasture, and George Minot.]

THE AMA RETORT

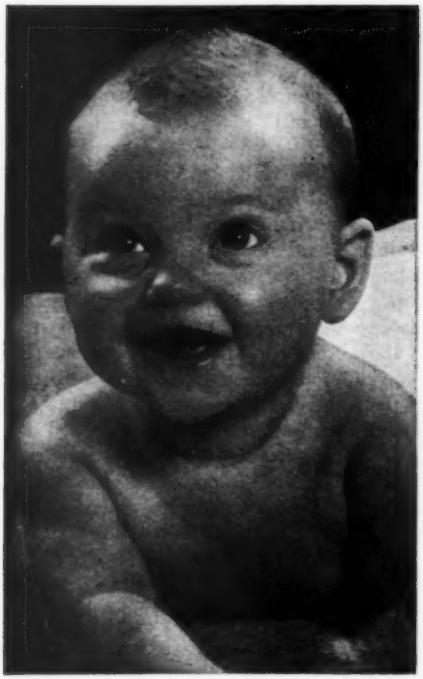
The preceding statement of protest requires an official reply by the Board of Trustees, since it is essentially a criticism of policies adopted by the House of Delegates, the representative body of the American Medical Association. The protest voices, moreover, distrust of the competence of the board to administer the funds developed by the special assessment and emphasizes disapproval by the signers of the leadership and policies of the association related to the extension of medical care.

Before analyzing the protest, the Board of Trustees calls attention to

No Exit

• I had just hung out my shingle and was pleased as punch with my shiny new office. My first patient arrived and was treated without incident. But when I escorted her to the exit, I found the newly-varnished door was stuck fast. I pushed and pulled, but it refused to give. While the patient looked on impassively, I had to get a screwdriver and remove the hinges. "Well," she remarked, when finally permitted to leave. "I never saw a doctor go *that* far to hold a patient." —M.D., NEW YORK

The Iron Age of Babies

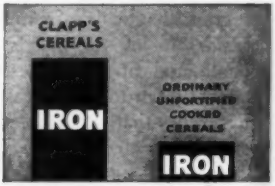


IN THE second month of a baby's life, as you know, the supply of iron he is born with starts running low.

Many doctors fill this need for more iron in the diet by recommending Clapp's Cereals after the 6-week checkup.

They specify Clapp's Cereals because:

Clapp's has more iron



Clapp's Baby Cereals contain 3 *times* as much iron as unfortified cereals. They also contain 2½ times as much Vitamin B_1, plus nonfat milk solids, wheat germ, and brewers' yeast.

Clapp's is finer in texture

Clapp's finer texture makes Clapp's Cereals easier to digest—and ideal for bottle and spoon feeding. Clapp's Baby Cereals dissolve almost immediately when mixed with warm milk or formula. And babies really like the taste of Clapp's. These are the reasons many doctors give when they recommend Clapp's Baby Cereals.

CLAPP'S BABY CEREALS

PRODUCTS OF AMERICAN HOME FOODS

the fact that not one of the signers of the protest attempted, through direct inquiry to the headquarters or to any official of the association, to determine

1. Whether or not the American Medical Association has a program for the extension of medical care.

2. Whether or not measures were in effect to promote the activation of such a program.

3. The activities related to determining existing unmet needs for medical care.

4. The relationships established by the association with organizations representing the farmer, labor, education, welfare, and similar groups.

Editor Morris Fishbein

The first sentence of the protest intimates that "a large segment of the medical profession is not in sympathy," etc. Actual surveys indicate that at least 85 per cent of the medical profession is in sympathy and is voluntarily contributing the assessment.

The remaining sentences of the first paragraph express doubt as to the manner in which the Board of Trustees will administer the funds arising from the special assessment. The Board of Trustees, under the constitution of the association, is charged with full responsibility for all funds and property of the association. The assets of the association are in excess of $10 million, and the annual expenditures in excess of $4 million. The assessment funds will be spent according to plans already made and for which budgets have been approved. The statement has already been published and is here reaffirmed that this fund is not for lobbying nor in any way a "slush" fund, but that it will be devoted chiefly to education of the American people as to the present high quality of medical service in our country, as to the inevitable deterioration, as shown in other countries associated with a governmental system of medical care, and also to accelerate in every way possible the enrollment of the people in voluntary hospitalization

President Roscoe L. Sensenich

Board Chairman Elmer L. Henderson

and medical care plans. This is the first time, since the association developed into an important, financially significant organization, that any doubt has even been hinted as to the dependability of the Board of Trustees in administering the funds.

The second paragraph of the protest begins with an "if" clause; the signers could have learned on suitable inquiry before signing that the funds are not being used for "legislative lobbying." If education and information of the public relative to medical care in the United States are "propaganda," the signers should understand that such education is a significant part of the association's program. The protest mentions an "already firmly rooted suspicion that the association's objectives are primarily economic and selfish"; the allegation is made without specifying the extent of this suspicion or the names of those in whom it is "firmly rooted." Can it be that the signers of the protest are thus "firmly rooted" in their views? When the four representatives of the signers met with the Board of Trustees, they were given full information as to the "comprehensive plan to extend and improve medical care and education." Whether or not they considered it "carefully worked out" and sufficient, did not become apparent. They did continue to insist that their protest be published, notwithstanding their admission of unfamiliarity with the details of the

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DESIGNED and built to the exacting ACMI standards, these new WAPPLER DIATHERMY UNITS incorporate many of the latest advances in electronic engineering. They combine foolproof frequency control with ample reserve power, adequate safeguards and rugged construction. Either of these new models assures the operator a wide range of dependable, trouble-free therapeutic applications, for effective heating of the deep tissues of the body. Optional accessories permit either model to be used for precise, minor electrosurgery.

Advanced Features of CC-3000

Meets Federal Communications Commission requirements as to frequency stability and harmonic or spurious radiations.

• Piezo-electric quartz crystal frequency control • Shielded, neutralized, push-pull oscillator circuit • Ample reserve power of 275 watts • Automatic overload protection for electrical components • Safety interlock switch • Automatic pre-set dosage timer • Resonance Indicator lamp • Patient "Shut-Off" cord • Interference and noise filter

Outstanding Features of VC-4000

Operates within the wave band allocated by the Federal Communications Commission, with a minimum of harmonic or spurious radiations.

• Frequency stabilized high C-L tank oscillator circuit • High frequency, balanced, push-pull oscillator circuit with Triode power tubes • Reserve power of 225 watts • Overload protection for electrical components • Pre-set Dosage Timer • Patient "Shut-Off" Cord • Resonance Control • Safety Interlock Switch

FCC TYPE APPROVAL No. D-481

FCC TYPE APPROVAL No. D-485

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Frederick J. Wallace, President

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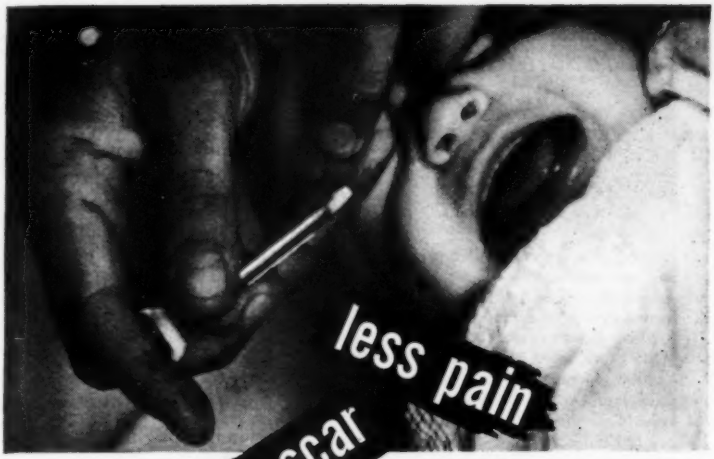
associations activities and its program.

The third paragraph of the protest alleges that the association has been unwilling to "acknowledge the need for improvement." This statement is without any support by actual evidence. The "comprehensive, constructive program" of the association is proof to the contrary. This program is an extension and a broadening of previous programs, many phases of which have already been implemented.

In the original communication received from this group, the final paragraph read: "The undersigned believe that now is the time to voice our disapproval of the leadership and policies of the association." About a week later, an additional clause was added indicating that this disapproval was limited exclusively to "the extension of medical care." When the four representatives conferred with the Board of Trustees, they admitted that the phrase had been added and the sentence modified without notifying the original signers of the protest.

The Board of Trustees is convinced that the circulation and issuance of this protest is an unfortunate disservice to the cause of the medical profession of the United States. It is not based on knowledge or fact as to the policies or activities of the American Medical Association.

[The signers of the above statement were the AMA general officers and trustees.] END



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Dr.....

Street.....

City.....State.....

Congress [*Continued from* 46]

promise that could prevent enactment of compulsory health insurance.

To combat this strategy, the Truman Administration can push from two directions: (1) An effort may be made to speed up enactment of many of the points in the moderate program via individual bills; and (2) the relatively noncontroversial points in the moderate program may be linked with health insurance in an omnibus bill.

Taft Dilemma

Somewhere along the line, Senator Robert Taft (R., Ohio) also will have to be reckoned with. For several years, he has sponsored legislation for Federal grants-in-aid to assist the states in providing medical care for the indigent. During the early months of the session, Senator Taft was so busy trying to save what he could of his Taft-Hartley labor law that he didn't bother to re-introduce his health bill. But as soon as the labor law was cleared away, he expected again to give attention to health legislation.

From the standpoint of the Democratic moderates, Senator Taft's activity in the health field presents a problem: They can't very well take their leadership from the Ohioan; but if he goes too far in his own bill, the Democrats won't have much room—short of the W-M-D plan—in which to operate.

Senator Taft and a group of Re-

publicans are working on their own four-point program, which centers around Federal aid to the states to help the medically indigent. They figure that this phase of the program might cover about 20 per cent of the population.

Other points of the Taft program are: (1) Federal aid to medical schools or students, or both; (2) Federal aid to the states for school health programs; (3) Federal aid to voluntary insurance plans.

Details of the last point are being worked out; but among the things Senator Taft has under consideration is a system of Federal licensing and regulation for companies underwriting voluntary insurance plans, in order to assure greater public confidence.

No Cabinet M.D.

The AMA doesn't have much chance of getting Point 1 of its twelve-point program: a Federal Department of Health, with a physician as the secretary. Instead the Truman-proposed Cabinet Department of Welfare (covering health, security, and education) is likely to materialize.

The House Committee on Executive Expenditures reported this bill after a voice vote that apparently was divided on a partisan basis. The measure would convert the Federal Security Agency into a Cabinet department, with FSA Administrator Oscar Ewing as Acting Secretary.

The idea of increased Federal aid to local public health units has met

no real opposition. Two bills are pending in the Senate and two in the House providing for such programs. However, a dispute is brewing over whether (1) funds should be earmarked to the states with specific instructions that they must be passed on down to local governments, or whether (2) the U.S. Public Health Service should be given supervisory authority over how the money is spent. In the first instance, the allotment of Federal funds would be automatic; in the latter, the Government would insist that each state produce a plan —which would have to be approved before Federal funds could be allotted.

At present, the PHS has a ceiling of $30 million in grants to the states for all public health purposes. Under the proposed expanded programs, the Federal Government would eventually earmark $78 million a year for the support of local public health units. Settlement of the procedural dispute and enactment of a bill this session appears likely.

Though there is no noticeable opposition on Capitol Hill, bills providing for Federal aid to medical education don't seem to be making much progress. Rep. George A. Smathers (D., Fla.) has several bills along these lines. One bill dealing with medical facilities would authorize Federal funds totaling $20 millon a year, to be distributed among the states on the basis of a complicated formula. Two other Smathers bills provide for

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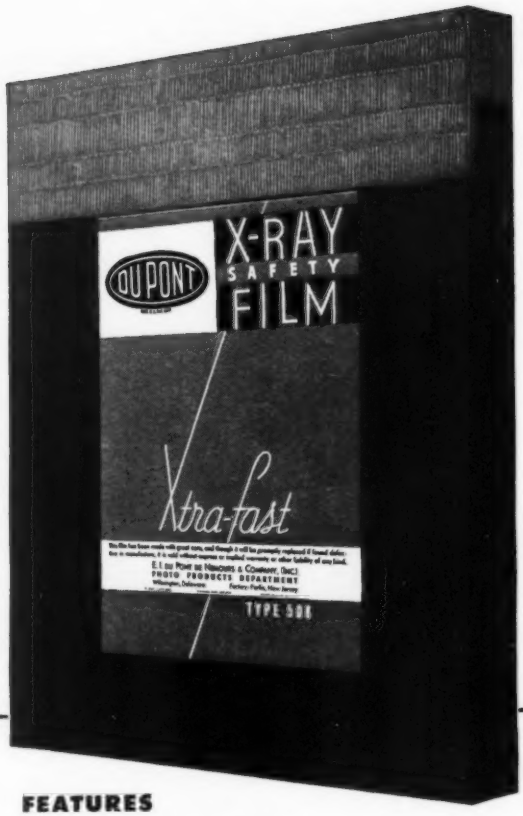

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BETTER THINGS FOR BETTER LIVING . . . *THROUGH CHEMISTRY*

Federal loans to medical and dental students who graduate in the upper portions of their high-school classes. The loans would bear a low rate of interest; payments would start ten years after the student graduated.

Expansion and liberalization of the Hill-Burton Act has been one of the most popular subjects for bills this session. One batch of bills would provide for general extension of the law, with an increase of from $75 to $150 million per year in Federal funds. Another group of bills would require the matching funds in the states to be equal to the Federal grants, but not twice as large, as now. A third group of bills would extend the Hill-Burton law backwards to include certain hospitals that were started before the Federal program was inaugurated. Some legislation dealing with Federal aid to hospitals can be anticipated. A bill providing increased funds looms as a good possibility.

A compromise National Science Foundation bill has been prepared, and its passage has been expected. But progress has been slow. Some believe that the measure has degenerated into the "ho-hum" category—no vigorous supporters, no violent opponents.

The usual crop of "splinter institute" bills would establish national institutes for research in the following fields, among others: arthritis and rheumatism (five bills); multiple sclerosis (twelve bills); cerebral palsy; and epilepsy. Another bill would establish a leprosy program and would prevent anyone in the U.S. Public Health Service from using the word "leper." Also in the House and Senate hoppers are the hardy-perennial bills authorizing the President to assemble all the world's experts in cancer for a concentrated attack on the ailment.

—WALLACE WERBLE

Medical Plans [*Cont. from* 54]

are going forward apace. Here, again, doctor cooperation counts heavily. Says one Blue Shield officer: "In several instances, doctors have been instrumental in getting community enrollment programs started." This is especially true in certain rural areas, where physicians are putting the heat on the plans to come out and do a job.

Community campaigns have met with varying success. The Michigan plan has, over the past two years, staged successful drives covering twenty-five communities ranging in population from 2,000 to 83,000. But other plans say that such programs result in a handful of group contracts, then bog down in a welter of individual transactions with the town's poorer risks. For this reason, quite a few plans are growing skeptical of community enrollment drives.

More plans are writing individual contracts than ever before, and all the big ones are tinkering with the idea. Michigan Medical Service is thinking of offering an individual contract with slightly restricted benefits and a 10 per cent higher premium (plan officials say duplication of the group contract on an individual basis would require a 50 per cent higher rate). Massachusetts Medical Service may offer group-contract benefits to individual signers, but demand a waiver of existing conditions.

Friction between Blue Shield and

in ocular emergencies
prevent infection with
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Prompt and continued use of SODIUM SULFACETIMIDE SOLUTION 30% eye drops immediately following removal of a foreign body—or after emergency treatment of abrasions, lacerations or burns due to chemicals—is rapidly gaining wide acceptance. Recent reports[1,2] emphasize the effectiveness of SODIUM SULFACETIMIDE SOLUTION 30% in preventing infection, hastening recovery and saving sight.

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PACKAGING. SODIUM SULFACETIMIDE SOLUTION (Sodium SULAMYD®) 30% is available on prescription in 15 cc. amber, eye-dropper bottles. SODIUM SULFACETIMIDE OPHTHALMIC OINTMENT (Sodium SULAMYD) is supplied in a concentration of 10% in ⅛ oz. tubes. SODIUM SULFACETIMIDE NASAL SOLUTION 10%, *with dl*-desoxyephedrine hydrochloride 0.125% is available in 15 cc. bottle with dropper. Schering's Sodium Sulfacetimide (Sodium SULAMYD) preparations contain 0.05% methyl and 0.01% propyl *p*-hydroxybenzoates as preservatives and are stabilized with sodium thiosulfate.

BIBLIOGRAPHY: 1. McGuire, W. P.: Virginia M. Monthly 75:330, 1948. 2. Uhde, G. L.: Am. J. Ophth. 31:323, 1948.

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Blue Cross, once considerable, is now on the wane. Sorest point currently is New Mexico, where both the Blue Shield and the Blue Cross plans are offering full hospital-medical-surgical insurance, in competition with each other. It's perhaps significant that New Mexico Physicians Service is the only physician-sponsored plan in the country that's in serious financial straits. It is pro-rating fee disbursements to doctors, paying only 50 cents on the dollar. (The seven other Blue Shield plans that lost money in the first nine months of 1948 were not victims of competition, but of their own tardiness in adjusting rates to benefits.)

What of future Blue Shield enrollment? Even the best current estimates could prove conservative if a couple of prospective developments pan out.

First is the boost that the new AMA campaign may give the plans. Publicists Clem Whitaker and Leone Baxter are solidly behind voluntary health insurance, not as "something to beat the Wagner bill, but as a desirable development in medical economics." W-B will turn out promotional pamphlets, slick up the plan's own literature, pressure M.D.'s everywhere to put in a good word for Blue Shield with their patients. If the campaign catches on, it could bring a real surge in enrollment.

Another possible factor is Blue Shield's program for setting up a national insurance corporation to handle some of the 11,000 national accounts that are interested in uniform contracts. In February, Associated Medical Care Plans presented to the AMA trustees a new twist on its earlier proposal* (blackballed by the AMA House of Delegates last fall). Latest scheme is for a national Blue Shield corporation, completely divorced from Blue Cross management and influence. The whole thing will probably be put up to the delegates again in June. —C. G. BENSON

*See "The Blue Cross-Blue Shield Alliance," MEDICAL ECONOMICS, November and December 1948.

Deaf Ear

● A colleague of mine was examining a small boy who had been brought to the clinic by his mother, a very talkative woman. During the examination my friend noticed that the youngster wasn't paying much heed to his questions. "Do you have trouble hearing?" the doctor asked.

"No," the boy answered. "I have trouble listening."

—M.D., ILLINOIS

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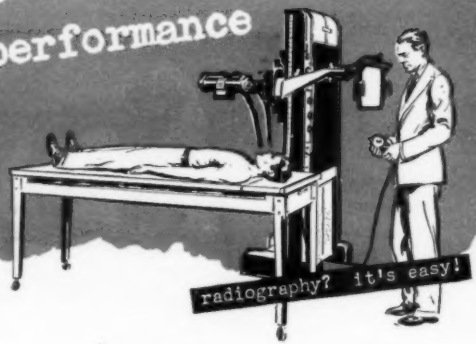

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tors, economic and political, bearing on the future of business profits. He predicts the course of security prices accordingly. (2) Mechanical. The investor ignores business and political factors. He concentrates instead on security prices themselves. From their pattern in the recent past he predicts their future. Best known mechanical method is the Dow Theory.* But there is no method, analytical or mechanical, that's infallible, even in the hands of an expert.

"*Industry Analysis.* Most industries follow a life cycle, with four definite phases: (1) experimentation, with high infant mortality, as in television before the war; (2) vigorous growth, with profits zooming, as in plastics and television today; (3) maturity, with steady profits, as in the chemical and automotive industries; (4) senility, with declining profits, as in the railroad and coal mining industries.

"Then, too, some industries have sharper ups and downs between boom and depression than do others. Most volatile are producers of raw materials or of factory durable goods (copper, steel, heavy machinery). Most stable are those producing goods for day-to-day consumption (foods, drugs). In between are producers of consumers' durable goods (autos, furniture). The investor should select his industries according to his primary objectives and the current phase of the business cycle.

"*Company Analysis.* Most industries are dominated by a handful of top concerns. The wise investor sticks to these leaders, leaving lesser fry to speculators. He studies each outfit's background, management, products, markets, capital structure, current financial position, earnings, and dividend records. Much of this data is published in investment manuals, such as Moody's or Standard & Poor's.

"*Portfolio Management.* Successful investment requires constant application. You can't just buy a security and forget it. A company doing well this year may be in trouble next year. The prudent investor follows the financial page of a big city newspaper, reads at least two investment journals regularly, studies all the literature his companies send him." [*Cont. on* 159]

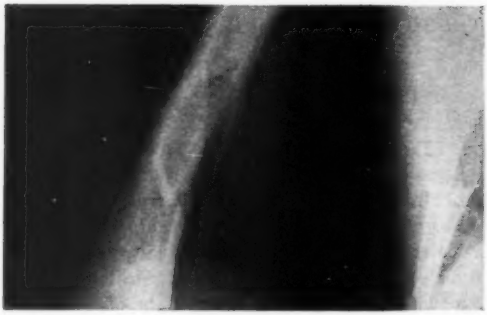
* See "How the Dow Theory Works," MEDICAL ECONOMICS, November 1948.

* HANDITIP *

Leather Cue

To prevent such leather items as chair coverings and book bindings from cracking and deteriorating, the leather industry recommends this simple beauty treatment: About twice a year, wipe the leather with a cloth moistened with glycerine. Allow the oil to soak in for a few minutes, then rub dry.

* * * * *



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Controls are simple . . . accurate. Control unit contains: voltage compensator for accurate adjustment of line supply; kilovolt control with three steps of 5 kvp each; a filament control for regulation of ma; and a hand timer and foot switch which plug into the control panel.

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(Stieglitz, E. J.: M. Ann. District Columbia 17:197, 1948)

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SQUIBB *Manufacturing Chemists to the Medical Profession Since 1858*

Paul Harris laid the book aside with a frown. What did the author take him for—a research institute? He couldn't keep up with his specialty journals, let alone The Wall Street Journal, Barron's Financial Weekly, the Kiplinger Letter, and whatnot.

Banker's Advice

For some moments he toyed with the idea of calling back the insurance agent. Then he remembered that somebody at the hospital had suggested he turn his problem over to an investment counsel. Next day the doctor dropped in at the bank to talk this over with his friend in the trust department.

Tactfully, the banker tried to kill the idea. Annual fees of investment counsel, he pointed out, start at one-half of 1 per cent on the first two or three hundred thousand dollars, scaling downward on larger accounts. Few reputable counsel accept accounts of less than $100,000. Some charge a minimum annual fee of $1,000.

But the banker had an alternative. Why not buy a share in the *bank's* common trust fund? This was a balanced portfolio—bonds and preferred and common stocks of numerous companies in many industries—designed for just such small investors as Dr. Harris. By pooling his kitty with others under the bank's management, he would have the whole problem off his hands. Besides, he'd be getting better diversification than he could get alone, even if he bought his stocks in only ten-or-twenty-share lots.

The bank's trust fund paid around 4½ per cent. It was three years old, and in that time had fluctuated in value about as much as the stock market as a whole.

Paul Harris thanked his banker friend and told him he'd think it over. Next he called on his friend in the brokerage business, half expecting to be sold a bill of goods. But the broker agreed at once that $20,000 wasn't enough to set up a well-rounded portfolio. He suggested the doctor buy into several sound investment trusts.

Best Buy

These offered the same advantages as a common trust fund, plus several other good points. For example:

¶ The investment trusts recommended by the broker were operated by large, well established investment counsel or management firms. These firms had bigger, better trained research staffs than had the local bank.

¶ By buying into a number of good investment trusts, the doctor would obtain not only diversification of investments, but also diversification of the management of his investments. Thus he would be hedging against possible errors of judgment by any one investment counsel or management firm.

¶ The recommended trusts paid an annual return of around 5 per cent. [*Continued on* 162]

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Vitamin B_6 (Pyridoxine Hydrochloride)	0.3 mg.
Niacinamide	15 mg.
Calcium Pantothenate	1 mg.
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(Equivalent by biological assay to 3.3 mg. International Standard Vitamin E)

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¶ All these trusts had been in operation for ten years or longer. In that time the shares of each had gained more in value than had stocks and bonds generally.

The doctor heaved an inward sigh of relief. This was for him. He told the broker he'd take the matter under advisement and let him know in a few days. But Paul Harris was pretty sure he'd found what he was looking for.

Investment Rx

Driving to his office, he turned the whole thing over once more in his mind. Mutual savings banks? They paid too little, gave him no play for his money. Government bonds? Same trouble. Besides, his present $10,000 worth was more than enough, in relation to his total funds, for immediate security purposes. Insurance annuities? He was well insured already. And an annuity alone, offering no protection against long-range inflation, seemed too risky for a man still many years short of retirement age.

For Paul Harris' money, a stock-and-bond program was clearly the answer. And investment trusts were the medium through which to carry it out.* His fund was too small for well-diversified direct investment. Anyhow, he had neither time nor training to manage properly an investment portfolio of his own.

That night at the dinner table

* A detailed article on investment trusts will appear in an early issue.

Acknowledged

"MERCURIAL DIURETICS IN HEART FAILURE. — . . . They often yield splendid results in individuals in whom physical signs of dropsy are lacking but water retention is demonstrated by the large loss of weight that follows the administration of a diuretic."

Fishberg, A. M.: Heart Failure, 2nd Ed., Phila., Lea & Febiger, 1946, p. 733.

"IN PERSONS WITH HYPERTENSION and in instances of heart failure with pulmonary congestion but without peripheral edema, mercurial diuretics may be helpful in hastening the loss of sodium or in permitting a somewhat more liberal diet. . . . In most cases hypertensive patients with normal blood urea levels can be safely tried on sodium depletion."

The Treatment of Hypertension, editorial, J. A. M. A. **135**:576 (Nov. 1) 1947.

". . . [By] the more frequent usage of the mercurials in cardiac dyspnea the attending physician . . . PROLONGS THE LIFE AND COMFORT of his patient."

Donovan, M. A.: New York State J. Med. **45**:1756 (Aug. 15) 1945.

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well tolerated locally, a diuretic of choice

- "Local effects of intramuscular injection. . . . The results strongly favored MERCUHYDRIN."

Modell, W., Gold, H. and Clarke, D. A.: J. Pharm. & Exper. Therap. **84**:284 (July) 1945.

- "The authors favor the administration of mercury intramuscularly rather than intravenously and for this purpose employ preparations such as MERCUHYDRIN."

Thorn, G. W. and Tyler, F. H.: Med. Clin. North America (Sept.) 1947, p. 1081.

- "The results of our experiments suggest that the greatest cardiac toleration for a mercurial diuretic occurs with MERCUHYDRIN."

Chapman D. W. and Shaffer, C. F.: Arch. Internal Med. **79**:449, 1947.

- "We have limited the use of chemical diuretics almost entirely to . . . MERCUHYDRIN."

Weiser, F. A.: Grace Hospital Bulletin, Detroit (Jan.) 1947, p. 25.

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he was on the point of telling his wife about it. What stopped him was her casual observation that the people next door had just ordered a new Cadillac. Also, the dishevelled mat she'd been using for a fur coat was about ready for contribution to CARE. "And don't you think, dear," she said, "that Junior could have a car at Yale next year? He wants one so."

"Hmm," said the doctor, dribbling his soup a little. He could feel his heart sink.

In a moment he brightened again. Suppose he *did* have to shave that $20,000 a bit. A couple of thousand one way or the other wasn't going to unbalance a fund placed in investment trusts. Funny the broker hadn't mentioned that as an additional advantage. Not a word had he said. Hadn't thought of it, maybe?

Paul Harris brightened further. No question about it, he told himself—he'd become a man of savvy and judgment in investment matters.

—LLOYD E. DEWEY AND P. J. DETURO

Anecdotes

¶ MEDICAL ECONOMICS will pay $5-$10 for an acceptable description of the most exciting, amusing, amazing, or embarrassing incident that has occurred in your practice.

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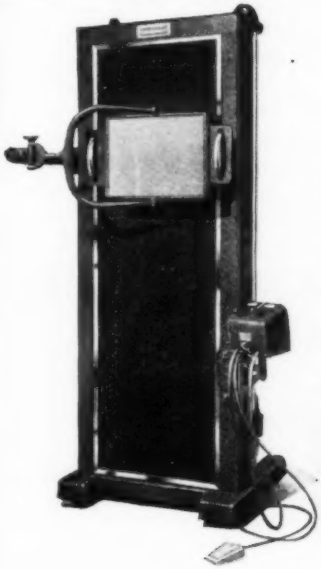

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The Newsvane

Doctor Fees Held Small Part of Medical Cost

It costs more to be sick today than it did seventy-five years ago—but not because doctors have increased their charges to any great extent. This is the opinion of Dr. Frederick H. Good, president-elect of the Denver County (Col.) Medical Society. He bases it on a comparison of prevailing fees with those published in a society fee schedule of 1871. Here are some of the standard fees of that day:

¶ Prescription, in office, $2-5.

¶ Physical examination, $5-10.

¶ Single visit in city, $4-5.

¶ Obstetrics, $30-50.

¶ Reducing fractures and luxations, $15-100.

¶ Attendance at court, as expert, $50.

¶ Plastic operations, $100-500.

Cracked Pot at End of Federal Rainbow

The gap between promise and performance in compulsory Federal insurance plans has been sharply pointed up by no less a person than Oscar R. Ewing. Speaking of old-age assistance, Mr. Ewing says: "Security means a sure knowledge that we shall not want for the basic necessities of life, no matter what fate may have in store, and that when we grow old we shall not have to face that once vivid spectre, the poorhouse. . . Tremendous progress has already been achieved. Today 43 million persons are covered by Old Age and Survivors Insurance."

Then, in a surprising burst of candor, Mr. Ewing says: "Old people who are entirely dependent upon their social security payments are actually enduring slow starvation."

Says G.P.'s Must Combat Specialists' Glamour

Many persons who by-pass the general practitioner and go directly to specialists later complain: "Why should I need five doctors to care for my family?" This attitude, says Dr. Stanley R. Truman, president-elect of the American Academy of General Practice, is a challenge to the G.P. He believes that 85 per cent of ailments can be—and should be—treated by family physicians.

Dr. Truman recently reviewed the records of 100 of his patients. He found that if they had gone directly to specialists for diagnosis

and treatment of all their ailments, the average patient would have seen three or four doctors.Obviously, says Dr. Truman, that procedure would have tripled the cost of medical care. The remedy, he adds, lies in the family doctor's hands: Practice such effective medicine that the public will forget its infatuation with the specialists' "glamour."

Water Cooler Works Three Ways

An electrically-operated water cooler now available for office use functions also as a midget refrigerator. It dispenses cool water, makes ice cubes, and has a cold-storage compartment for pharmaceuticals. No plumbing connections are needed, since the cooler uses bottled water.

Says Bureaucrats Suffer Mental Constipation

Uncle Sam should graduate from a medical school before he takes up medical practice; the political reformer does not belong in the operating room. So says Representative Charles J. Kersten (R., Wis.), who believes there are stronger reasons for socializing many industries than for socializing the professions.

"The Administration's social reformers say the AMA is stuffy and reactionary," states Representative Kersten. "But for constipation of intellect, exasperating duplication, and waste, I have seen the choicest

YOUR CHOICE OF HEMATINICS

HEMONUTRON

NION

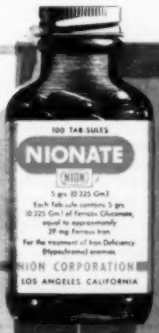
LOW COST IRON THERAPY PLUS B COMPLEX WITH LIVER AND YEAST

The suggested daily dose of Hemonutron (6 tab-sules) provides:

Iron (*Ferrous Gluconate*) . . 18 grains

B Complex

Liver Concentrate	576 mgs.
Yeast Concentrate	192 mgs.
Thiamin Chloride	3 mgs.
Riboflavin	3 mgs.
Niacinamide	21 mgs.



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WHEN PATIENTS REQUIRE IRON ALONE

Each Nionate tab-sule contains 5 grains (0.325 gm.) of Ferrous Gluconate

Both contain Ferrous Gluconate –the Iron salt of choice

Both Hemonutron and Nionate are available in bottles of 100 tab-sules *(capsule-shaped tablets)*

NION CORPORATION • LOS ANGELES 33, CALIFORNIA

examples in Federal bureaucracy. It is a shame the average American citizen is so far removed from the Washington scene as not to be aware of it first hand." He challenges the Administration to clean house in the health fields in which it is already active before asking adoption of a national health scheme.

New Medical Specialty Board Created

The rapidly growing Advisory Board for Medical Specialties recently announced a new board, the American Board of Preventive Medicine and Public Health. It turned thumbs down on specialty boards for allergy and proctology. Next on the ABMS agenda may be the setting up of a full-time office and staff.

AMA Outlines Rural Health Program

In its program to raise rural medical care standards, the AMA Committee on Rural Health is putting new stress on:

Medical scholarships to students agreeing to practice in rural areas. These will be provided by medical associations, farm bureaus, and through legislative appropriations.

State and county health councils, whereby doctors promote health education in cooperation with civic groups.

Voluntary prepay plans expanded to include the medically

SOLTABS®

CSC

The New Registered Name for SOLUBLE TABLETS CRYSTALLINE PENICILLIN G POTASSIUM

For convenience in prescribing, SOLTABS has been adopted as the new name for Soluble Tablets Crystalline Penicillin G Potassium-C.S.C. When you use the name Soltabs on your prescription you are assured of your patients' receiving the original penicillin soluble tablet.

Now in 2 Potencies

100,000 AND 50,000 UNITS PER TABLET

Repeated requests for a higher potency tablet have resulted in the introduction of 100,000 unit Soltabs. These tablets, like the 50,000 unit tablets, contain neither binder nor excipient. Soltabs are widely used in pediatrics for oral administration of penicillin dissolved in the milk formula or in water. Also applicable in aerosol inhalation therapy where they greatly simplify dosage calculation and preparation of solutions for administration.

EACH TABLET INDIVIDUALLY WRAPPED IN FOIL

SUPPLY

Soltabs—Soluble Tablets Crystalline Penicillin G Potassium-C.S.C. are supplied in boxes of 24 tablets, 50,000 units or 100,000 units per tablet, each tablet individually wrapped in foil.

C.S.C. Pharmaceuticals

A DIVISION OF COMMERCIAL SOLVENTS CORPORATION, 17 EAST 42ND STREET, NEW YORK 17, N. Y.

indigent—which may involve some state aid.

Standards Evolved for Co-op Health Plans

The AMA Council on Medical Service has drawn up a set of standards for cooperative health plans. When it meets to discuss them with representatives of the Cooperative Health Federation, most of the argument will probably center on the stipulation that co-ops get the approval of county medical societies. The co-ops would prefer direct AMA endorsement. They claim that some county societies oppose them *per se*.

A possible barrier to blanket approval, from the AMA viewpoint, is the power often delegated to lay managers of the health co-ops. In Wisconsin, for example, a co-op manager is empowered to (1) make up a list of approved drugs and require staff doctors to use only those drugs; (2) approve or order house and night calls; (3) insist that payments for medical service to nonmembers be made to the co-op, not to the doctor.

Thinks Voters Should Do Their Own Lobbying

Give the people the facts on Government medicine and they will do their own lobbying against it. So says Legislative Analyst Marjorie Shearon. "There is less need," she declares," for lobbyists in Washing-

ton than there is for informed citizens at the grass roots. Senators and Congressmen are allergic to lobbyists, but how they listen to their constituents!"

The best thing, she feels, is to tell the people exactly what socialized medicine would cost and how it would be administered. Says Mrs. Shearon: "Explain the capitation system. Don't be lurid. The *facts* are terrible enough."

Society Helps Towns Find Doctors

The Wisconsin State Medical Society has worked out a plan for giving doctorless towns a chance to obtain physicians. When the state's medical examiners meet with applicants for Wisconsin licenses, the society invites representatives from communities in search of a doctor. Each town tells the new licensees about its opportunities.

Of twelve communities applying last year, three got doctors, eight have prospects.

New Medical Bag Holds More Equipment

Every physician who's struggled to shut a jam-packed satchel knows about one shortcoming of the old-faithful Boston-type bag: It won't close if filled to the top. The waste of space that this entails has been overcome in a new, zipper-topped "Opn-Flap" bag. The Opn-Flap can be piled to the brim, holds a third

in swords or needles

nothing holds an edge like tempered steel

Only VIM needles are made of "Laminex" stainless steel. Unlike other steels, "Laminex" steel can be heat-treated to give it a true spring temper. That's why VIM "Laminex" needles stay sharper longer, need replacement less frequently. **Specify...**

hypodermic needles and syringes

VIM

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more than ordinary bags the same size. It is made of soft leather, lined with rubber; weighs only 2½ pounds.

U.S. Seen in Dire Need Of Psychiatrists

Nearly 1,000 jobs are going begging for lack of psychiatrists to fill them, says Dr. William C. Menninger, president of the American Psychiatric Association. Most urgently in need of personnel, he declares, are state mental hospitals, community clinics, and V.A. hospitals, which offer salaries ranging from $4,000 to $15,000. Even this list of vacancies doesn't adequately reflect the national shortage of psychiatrists, says Dr. Menninger. He estimates the country's overall need at 15,000, against a current supply of less than 5,000.

New Tires Designed For Safer Driving

The physician shopping for tires can now choose from a variety of newly-developed casings and tubes built to minimize road hazards. Here are some samples of the new products now on the market:

Tubeless tire. The inside lining is made of gooey, puncture-proof rubber. Cost is several dollars more than the conventional tire-and-tube combination.

Snow tire. This type has knobby treads and (in some models) abrasive particles, helpful on ice. The mileage life of such tires may be

When dermatological symptoms are caused by . . . .

Cosmetic Allergy

Physicians are becoming more and more aware of the increasing incidence of cosmetic allergy. Dermatitis venenata, eczematoid eruptions, exfoliative dermatoses, pruritis, cheilitis, erythema, and urticaria, as well as respiratory problems are commonly seen and are now recognized as being frequently due to a cosmetic sensitivity.

When cosmetics irritate sensitive skins, or aggravate existing dermatological symptoms, it is well to remember —*and prescribe*—AR-EX Hypo-Allergenic Cosmetics—formulated in close cooperation with the medical profession, clinically tested for their hypo-allergenic properties—and a genuine pleasure for your patients to use. In fashion-right shades.

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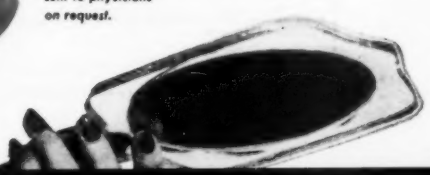

only 60 per cent of standard.

Self-sealing tube. A layer of soft rubber swathes any sharp object penetrating this tube. When object is withdrawn, rubber seals the hole.

Waffle tube. A waffled surface of excess rubber retards puncture leakage, helps you get to the garage before your tire goes flat.

Nurses Would Delegate Some Jobs to Aides

State laws that sharply limit the nursing field need not hamper hospitals, says the New York State Nurses Association. While a nurse-practice act for that state was being debated, the association issued a list of more than 100 services that may be performed by orderlies, aides, etc. It also suggested that hospitals redistribute work so as to take some of the strain off depleted nursing staffs.

Sees Need for Joint Insurance Plan

Unilateral action by Blue Cross or Blue Shield cannot remedy the present deficiencies of the voluntary health insurance set-up. This is the opinion of Dr. George Baehr, retiring president of the New York Academy of Medicine. He regrets the recently lost opportunity to initiate a national voluntary health service under joint Blue Cross-Blue Shield sponsorship.

"The proposed joint plan had

In the **J.A.M.A.**'s "QUERIES AND MINOR NOTES"...

an authority lists eight specifications for a preparation to use in the nose:

1. It "should have a moderate decongestant effect."
2. It "may contain . . . penicillin."
3. It "should not vary greatly in . . . pH (5.5 to 6.5) from that of normal nasal secretions."
4. "Nor . . . be harmful to ciliary action."
5. It "should not injure the nasal mucosa."
6. It "should be isotonic with the blood."
7. It "should not cause undue secondary side reactions."
8. It should not "cause the blood pressure to rise unduly."

Each of these specifications is fulfilled by

Par-Pen

the penicillin-vasoconstrictor combination for intranasal use*

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Smith, Kline & French Laboratories, Philadelphia

*Sodium crystalline penicillin, 500 units per cc.; Paredrine hydrobromide 1%.

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many defects," he says, "but to my mind it had at least the merit of getting a national voluntary program established." He adds: "If joint action by both associations is eventually consummated, the many community-sponsored, industry-sponsored, and cooperative medical care plans now in successful operation cannot be ignored."

For ultimate success, Dr. Baehr feels, voluntary prepayment plans must (1) encourage and support group practice; (2) pull gradually away from exclusively fee-for-service remuneration; and (3) provide comprehensive care.

Soviet Doctors Told To Be 'Practical'

Russian doctors are being told bluntly to cure patients with the materials and techniques they have at hand, and to play down such things as laboratory and clinical research. Like all science in the USSR, medicine must now adhere strictly to the Communist party line. That line is: "Make do with what you have—but get results!" There isn't enough medical equipment to go round. Disease—stemming largely from nutritional deficiencies—is on the increase. Shortages of vaccines and serums make practice difficult, while inadequate sanitation and overcrowding contribute to the prevalence of both endemic and epidemic diseases.

Stalin and his key officials have become convinced that traditional research is wasteful of time and

"It's the same thing every month!"

But It Needn't Be!

There's never a time when Anacin can bring more gratifying relief than during the menstrual period. Why not advise your patients who suffer periodic cramps to take Anacin tablets. Its dependable A-P-C formula will give fast, effective relief with a duration of action that exceeds the effectiveness of plain aspirin. Anacin is easily available to you and your patients at all hospital pharmacies and drug stores.

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equipment. Today every scientist is expected to make "practical" contributions to the Russian effort. Medical men, for example, are expected to provide offsets for poor nutrition.

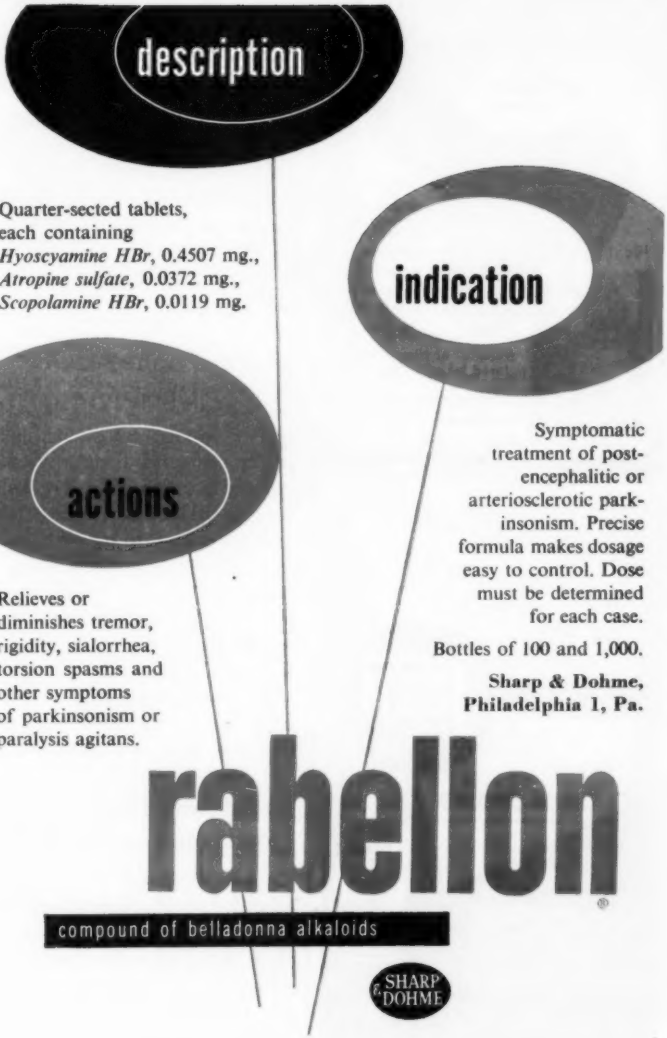
Hospital Salaries Show 10 Per Cent Increase

Salaries of hospital employes went up in 1948; working hours went down. The American Hospital Association reports that the present starting salary of general-duty nurses averages $204 a month. This is $17 more than the 1947 average.

For all hospital personnel except clerks, the work week was cut one hour, to an average of forty-six hours. General-duty nurses in the hospital worked an average of forty-five hours a week, received paid vacations of sixteen days per year.

Says Bill Collectors Alienate the Public

Good relations with the public can be developed only at the physician-patient level, says the Alameda County (Calif.) Medical Association. It advises each county society to establish a local program that includes: (1) establishment of a fee-complaint committee to adjudicate claims of excessive charges; (2) collection work by the society's bureau of medical economics, to eliminate offensive tactics of commercial agencies; (3) a firm stand against rebating and fee-splitting;


description
Quarter-sected tablets, each containing *Hyoscyamine HBr*, 0.4507 mg., *Atropine sulfate*, 0.0372 mg., *Scopolamine HBr*, 0.0119 mg.
indication
Symptomatic treatment of post-encephalitic or arteriosclerotic parkinsonism. Precise formula makes dosage easy to control. Dose must be determined for each case.
Bottles of 100 and 1,000.
Sharp & Dohme, Philadelphia 1, Pa.
actions
Relieves or diminishes tremor, rigidity, sialorrhea, torsion spasms and other symptoms of parkinsonism or paralysis agitans.
rabellon®
compound of belladonna alkaloids
SHARP & DOHME

and (4) a plan to furnish adequate medical care to each member of a community, regardless of his financial status.

The Alameda society is caustic on the subject of collection agencies. "One-fourth or more of the families in most communities," it says, "have been hounded for payment of a disputed bill by commercial bill collectors. To these millions of people, collectors have been the 'public relations representatives' of the free enterprise system in medicine."

Society Phone Service Has 17 Operators

Half a million telephone calls a year are now handled by the medical bureau of the District of Columbia medical society. It stands ready, round the clock, to supply the name of a doctor to any caller who needs one. In addition, it provides private-wire secretarial service for 250 subscriber-physicians, and telephone-answering service for another 365. The bureau has a staff of twenty, including seven full-time and ten part-time telephone operators.

Examiners May Clamp Down on Foreign M.D.'s

Doctors graduated after 1935 from medical schools outside the U. S. face a possible blanket exclusion from state board examinations. This ban was recommended recently by the Federation of State Boards of Medical Examiners. It stems from

How mild can a cigarette be?

In a recent coast-to-coast test, hundreds of men and women smoked Camels—and only Camels—for 30 consecutive days. These people smoked on the average of one to two packs a day. Each week throat specialists examined these Camel smokers. A total of 2470 careful examinations were made. The doctors who made the throat examinations of these Camel smokers reported:

"NOT ONE SINGLE CASE OF THROAT IRRITATION due to smoking CAMELS!"

According to a Nationwide survey:

MORE DOCTORS SMOKE CAMELS

than any other cigarette

Doctors smoke for pleasure, too! And when three leading independent research organizations asked 113,597 doctors what cigarette they smoked, the brand named most was Camel!

Money-Back Guarantee!

Smoke Camels and test them in your own "T-Zone"—T for taste, T for throat. If, at any time, you are not convinced that Camels are the mildest cigarette you have ever smoked, return the package with the unused Camels and we will refund its full purchase price, plus postage. *(Signed)* R. J. Reynolds Tob. Co., Winston-Salem, N. C.

what was described as "the marked deterioration in foreign medical teaching and equipment since 1935." Another contributing factor: One of every two foreign graduates examined by U.S. boards between 1930 and 1947 failed to pass.

The proposed ban does not affect graduates of Canadian schools.

ANA To Gauge Nursing Strength of Nation

An inventory of all registered nurses in the U.S. is being conducted by the American Nurses Association at the request of the National Security Resources Board. The NSRB will fit the data into its overall plan for military, civilian, and industrial mobilization in case of war. The ANA questionnaire seeks information on each nurse's marital status, number of dependents, present employment, and special training.

Thinks Medicine's Leaders Should Set Policy

Don't place any reliance on "grass roots" opinion in the medical profession, warns Dr. L. Howard Schriver, president of Associated Medical Care Plans. The average doctor, he contends, neither understands nor cares much about the socio-economic problems of medicine. The profession, says Dr. Schriver, should look to those whom it has put in "high position" to develop effective policies and programs. "If they refuse to assume

one of the reasons why you get quick results with Feosol Tablets

Feosol Tablets' special vehicle and coating ensure disintegration in the acid medium of the stomach and upper duodenum —the region most favorable to iron absorption. That is one of the principal reasons why Feosol Tablets achieve such rapid hemoglobin regeneration, such prompt reticulocyte response.

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Feosol Tablets

the standard form of iron therapy

Microphotograph of cross section of Feosol Tablet

A special protective coating of fatty esters prevents oxidation of the ferrous sulfate to the relatively ineffective ferric form.

1 Outer coating

2 Under coating

3 Protective fatty esters

4 Compressed ferrous sulfate

this obligation," he adds, "they demonstrate their unfitness."

The profession has created a great market for its services, Dr. Schriver points out. But he believes that, through lack of unity, it has made only feeble efforts to meet the demand. "As vendors," he says, "we should accept the challenge that solving the problem of distribution is an obligation. . . We have the vehicle to accomplish this end—the professionally sponsored voluntary prepayment plans."

Government Medicine No Boon to Health

The method of paying for medical care has little bearing on the health of a nation, reports the Research Council for Economic Security. It bases this conclusion on a study of mortality rates and life expectancy in nine countries. Three of the nations—New Zealand, England, France—had compulsory health insurance plans. Three—Sweden, Denmark, Belgium—had state-aided voluntary plans. Three—Australia, the U.S., Canada—had private, voluntary plans. From an actuarial viewpoint, the health of all seemed about on a par.

It should not be assumed, says the council, "that the adoption of any system of paying for medical care, compulsory or otherwise, will make for a decided improvement in the health indices. There is good reason to believe that better results might be expected from improvement of living standards, good nutrition, elimination of economic and social inequalities between races, development of medical facilities, preventive health measures, and other factors which directly affect the health of the people."

Midwives Catching Few Infants These Days

Midwives are rapidly vanishing from the American scene. They attended 10.7 per cent of all births in 1935, the Metropolitan Life Insurance Company reports; but by 1947 they attended only 4.8 per cent. Metropolitan says that the decline of the midwife parallels the passing of foreign-born women who preferred the systems of the "old country." Forty years ago, in New York City, midwives attended more than 50,000 maternity cases a year —or 44 per cent of the total. Now they are present at less than 1/10 of 1 per cent of that city's cases.

Army Charges Abuse of Free Medical Care

To avoid waste of critically-needed Army medical personnel, the Army and Air Force recently ordered servicemen and their families to stop calling a military physician every time the baby burps. Said the Army: "The convenience of medical facilities in certain areas and the fact that there is no direct cost involved prompts dependents to request treatment for many condi-

tions, often minor, for which they would not consult a civilian physician were they members of a civilian community."

Public Gets Facts On Chiropractic

A booklet entitled "Myth and Menace—The Truth About Chiropractic" is being distributed to the public by the New York State medical society as part of its continuing campaign against state legalization of the cult. Written in layman's language, the booklet exposes the basic fallacies of chiropractic. It gets off to a quick start by asking the reader to imagine that his car has developed serious engine trouble on a country road.

> Looks like a job for a competent mechanic [the booklet continues]. Along comes a man who notices your plight. "If your car's out of order, you'd better see Elmer Jones, up the road," he volunteers. "He'll fix you up."
>
> "Is Jones an expert on automobile engines?"
>
> "Well, not exactly. But he adjusts spark plugs."
>
> "But this may be complicated motor trouble," you point out. "I need a man who really understand automobile engines."
>
> "Oh, that's all right," your informant retorts. "Jones is one of those fellows who fixes any trouble in your car by adjusting the spark plugs. He went

Now... two delicious S.K.F. sulfonamide preparations:

These pleasant-tasting preparations may be prescribed wherever oral dosage of the sulfonamides is indicated.

new!.. Eskadiamer

a *combination* fluid sulfonamide containing equal parts of sulfamerazine and sulfadiazine—the two safest sulfonamides in general use.
Each 5 cc. (one teaspoonful) contains 0.25 Gm. (3.86 gr.) sulfamerazine and 0.25 Gm. (3.86 gr.) sulfadiazine.

Eskadiazine

the widely-prescribed fluid sulfadiazine which provides desired serum levels much more rapidly than sulfadiazine in tablet form.
Each 5 cc. (one teaspoonful) contains 0.5 Gm. (7.7 gr.) sulfadiazine.

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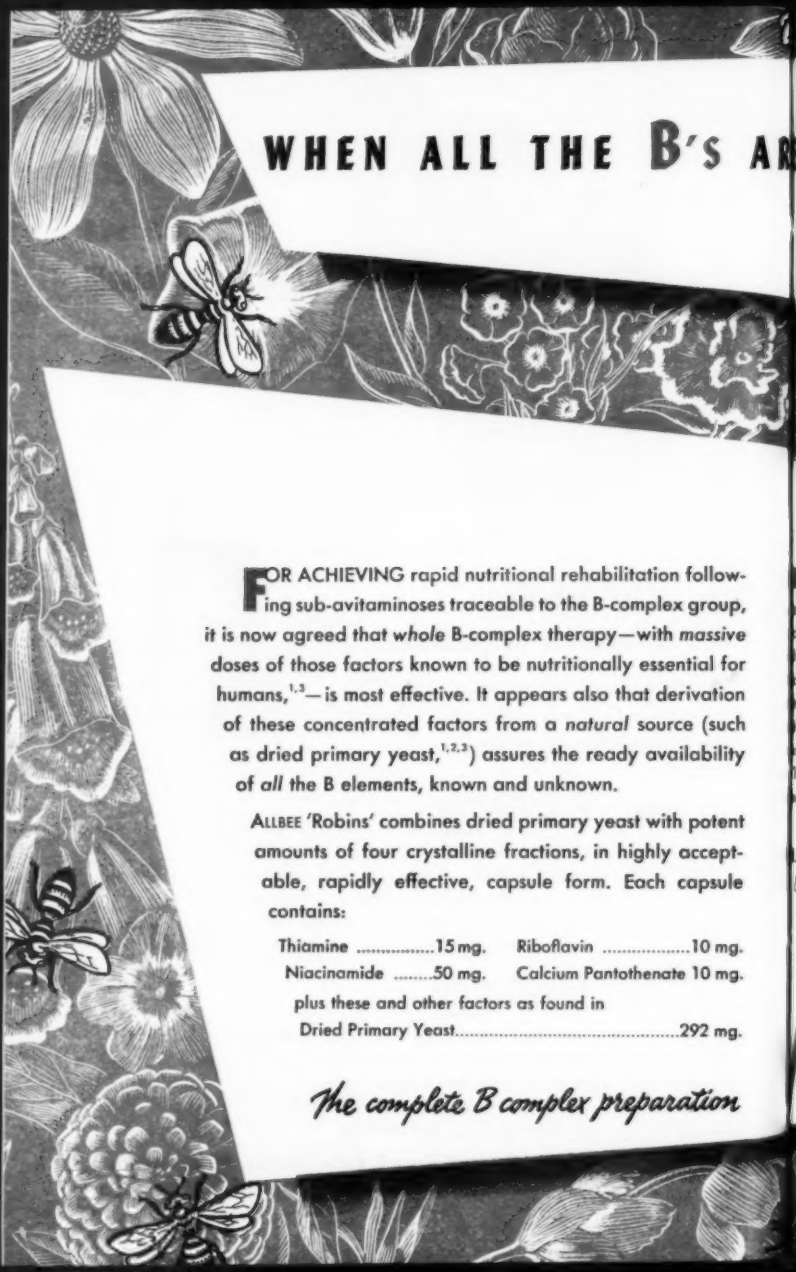

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FOR ACHIEVING rapid nutritional rehabilitation following sub-avitaminoses traceable to the B-complex group, it is now agreed that *whole* B-complex therapy—with *massive* doses of those factors known to be nutritionally essential for humans,[1,3]—is most effective. It appears also that derivation of these concentrated factors from a *natural* source (such as dried primary yeast,[1,2,3]) assures the ready availability of *all* the B elements, known and unknown.

ALLBEE 'Robins' combines dried primary yeast with potent amounts of four crystalline fractions, in highly acceptable, rapidly effective, capsule form. Each capsule contains:

Thiamine	15 mg.	Riboflavin	10 mg.
Niacinamide	50 mg.	Calcium Pantothenate	10 mg.

plus these and other factors as found in Dried Primary Yeast ..... 292 mg.

The complete B complex preparation

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LLBEE WITH C 'ROBINS'

EE with C—new companion product to ALLBEE—
ks the *highest strength of ascorbic acid available today in a*
ti-vitamin capsule! This new Robins' Triumph now permits
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ter-soluble factors so necessary to normal cell metabolism
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xcelled potency, far above daily adult requirements.
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ctors found in ALLBEE, with the addition of
250 mg. of Ascorbic Acid in each capsule

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Ethical Pharmaceuticals of Merit since 1878

70th ANNIVERSARY YEAR—1878 to 1948

REFERENCES
1. Jolliffe, N.: J.A.M.A., 129:613, 1945
2. Ruskin, S. L.: Am. J. Dig. Dis., 13:110, 1946
3. Spies, T.: J.A.M.A., 125:245, 1944

ALLBEE *a Robins Triumph*

to a school and took a course in it. He says any mechanical trouble can be cured by putting the spark plugs in shape. You don't have to worry about your motor."

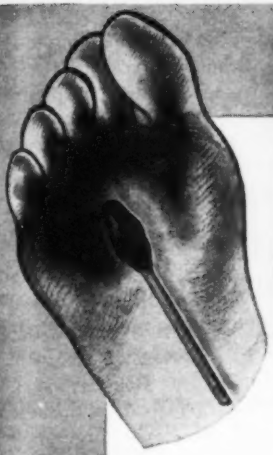
No sane motorist would fall for such bunk, the booklet points out. "Yet," it says, "the same car owner may fall victim to the same kind of reasoning when it is his own body that needs attention."

Says Schedules Would Avert Fee Disputes

County societies should publish minimal fee schedules, says the Utah State Medical Association. Then, it points out, patients would have a general idea of medical costs in the area and would be disinclined to dispute bills that vary a few dollars from the norm. The association also warns that it is ready to crack down on any doctor who is guilty of fee gouging.

V.A. Cuts 16,000 Beds Off Building Plans

At President Truman's behest, the Veterans Administration has canceled plans for twenty-four new hospitals. It is reducing the projected size of fourteen others. Total curtailment will be 16,000 beds. Mr. Truman has told Congress that veterans with non-service-connected ailments should be cared for under a national compulsory prepayment program, and not as



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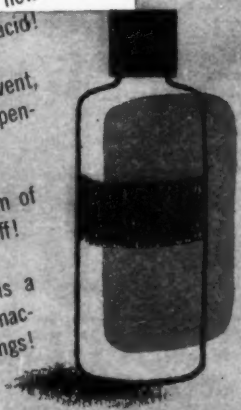
NEW in effectiveness . . . contains the new and more fungicidal COPPER salt of undecylenic acid!

NEW in vehicle . . . a lipophilic, fat-solvent, low surface tension liquid that provides greater penetration of the fungicide!

NEW in prolonged action . . . the film of fungicide stays on and in the skin—will not rub off!

NEW in convenience . . . Decupryl is a rapidly drying liquid that avoids messiness and maceration of ointments; requires no protective dressings!



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Please send me a sample of DECUPRYL, with detailed literature and special treatment routine forms for patients' use.

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wards of the V.A. According to Veterans Administrator Carl R. Gray Jr., two out of three hospital admissions are for non-service-connected cases. He adds that revision of the building program will save $280 million.

Debt of Gratitude Paid Too Late

When he heard that Pilot Robert Gloe was wrecked on nearby Bear Mountain, Dr. Robert Dykes of Taft, Calif., rushed to the rescue. Dr. Dykes had not forgotten that Gloe was the man who had parachuted to him with medicines and supplies when he was similarly wrecked in Utah.

For five days the rescue party struggled up Bear Mountain through ice and snow. Some wanted to quit, but the doctor wouldn't hear of it. When they reached the demolished plane, one passenger was living, three were dead. Among the latter: Robert Gloe.

Federal Aid Won't Cut Standards: Scheele

Federal aid aimed at increasing the number of workers in medical fields must (1) raise the output of present medical schools and (2) provide new educational facilities. This is the view of Dr. Leonard A. Scheele, Surgeon General of the U.S. Public Health Service. He believes that Federal aid need not cause deterioration in teaching

DR. VERRIE WYSE

¢OLLE¢T$

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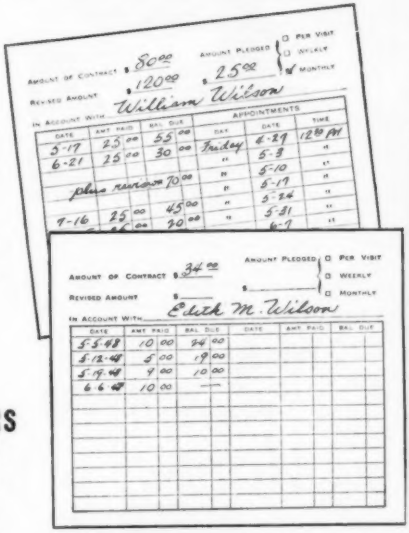
This way . . .

WITH CONTRACT CARDS

By using these cards you get paid as the work progresses. They make collecting a simple routine matter with each visit. The patient knows what you're to do for him and he knows how much and how you expect him to pay. No worrying, no mistakes, no misunderstandings, no uncollectible fees, no lost patients.



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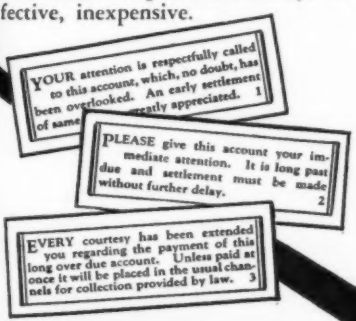

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standards or loss of independence by the professional schools. A time limit, he says, should be placed on any Federal aid program, with a requirement for periodic reports on its effectiveness.

Adds Dr. Scheele: "If a broad program of Federal aid for medical education is authorized, the Public Health Service hopes to play as acceptable a role in its administration as we now play in aid to research and special fields of training."

Says Compulsory System Doesn't Guarantee Care

Compulsory health insurance is national socialism in the least appropriate field, says Columnist Dorothy Thompson. "It seems certain," she declares, "that we are going to take another step on the road to bureaucratic collectivism by the passage of a compulsory health insurance bill. A mere 150,000 physicians, 90 per cent of whom are against it, cannot buck the trend. Besides, they are supposed to be prejudiced, on the current theory that those who know most about anything are not reliable witnesses."

What we really need, Miss Thompson adds, is more genuinely free medicine for people in real jams.

Under compulsory health insurance, she asks, "just what services does the Government guarantee the taxpayer for his money? When his wife is in labor, will it guarantee a bed and a physician at the critical moment? Don't make

me laugh! I have lived under such medical systems in England, Austria, and Germany. They were awful."

Kin Discuss Patients With Hospital Staff

"Now I understand what you are trying to do for us, and I'll be more patient." That remark is typical of many heard on "Interview Night" in Montefiore Hospital, New York. One evening a week the hospital throws open its doors to the relatives of patients. It invites doctors, consultants, psychiatrists, and social workers to discuss cases with them. Each physician is encouraged to give as much time as he can to explaining the nature of the illness, its complication, and prognosis.

Montefiore reports that the plan has been successful not only in easing anxiety but in giving physicians an insight into home life and other factors that may have a bearing on a case.

Explains Check-Up on Doctors' Tax Returns

Economist Curt Gruneberg of the University of Kansas City doesn't go along with the much-quoted Fortune Magazine statement that "There have been more doctors convicted of tax evasion than any other group except professional gamblers." Such a statement cannot be supported factually, he recently told the New York State medical society, because (1) there are no

over-all statistics on tax convictions of any professional or occupational group; and (2) "professional gamblers" are not listed separately in the Treasury Department's classification of taxpayers.

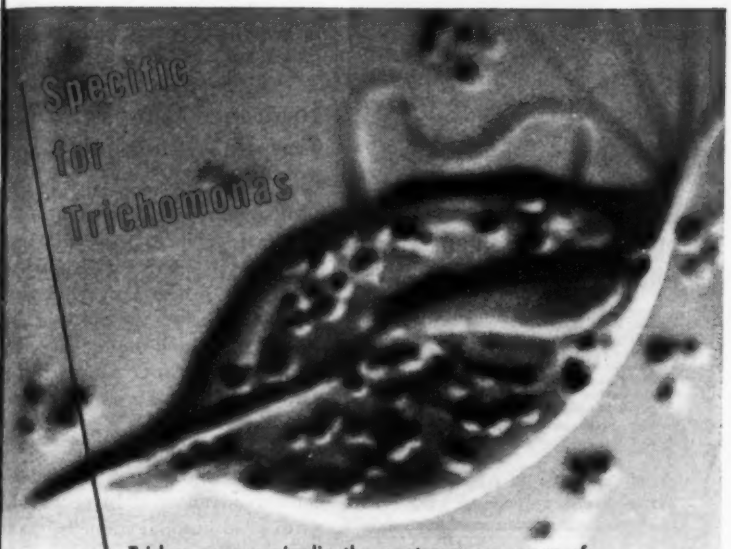
"Nevertheless," says Mr. Gruneberg, "there seems to be something wrong with tax returns of doctors. The Treasury Department has selected nine categories of occupations or professions whose tax returns are given particular attention. Physicians are one of these nine groups."

Reason for this, he declares, is the physician's "lack of detailed financial records," plus the fact that many medical fees are paid in cash. But Mr. Gruneberg believes this special scrutiny of doctors' tax returns may eventually be done away with.

"More patients are paying their medical bills by check rather than cash," he says; "more patients who still pay in cash ask the doctor for a receipt; and more doctors are now convinced of the necessity for satisfactory income records."

Business May Be Brisk At the Body Bank

Watching the development of blood, eye, and bone banks—plus an artery bank established in Boston—the Detroit Free Press muses: "We're afraid that if this business of getting spare parts for the human body is carried much further, it won't be long before mamma will



Trichomonas vaginalis, the most common cause of leukorrhea, is readily eradicated by Devegan. Furthermore, Devegan restores the normal vaginal flora and pH level, relieves irritation, and eliminates the offensive leukorrheal discharge. Powder for insufflation at the office (10 Gm. vials, 1 oz. and 8 oz. bottles). Tablets for patient's use at home (boxes of 25 and 250).

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lead the old man to the nearest hospital and, by paying $11.98, trade him in for a brand-new model."

Insurance Companies Test Hospital Admission Plan

Blue Cross may soon face stronger competition from private insurance companies. Up to now, the latter have been operating under this drawback: Their insured patients had to deal with the hospital on a cash basis, initial deposit included. All the Blue Cross patient had to do, of course, was present his membership card.

Now the companies have a plan that will give their subscribers similar advantages. In cooperation with local hospital councils, the insurers will prepare master cards for each hospital. These cards will indicate the exact extent of coverage for each subscriber group. When a patient presents his membership card, it will be easy to verify his coverage. The plan has been under test by forty-four companies and seventy hospitals in Chicago since last December and appears to be working well.

Says the Accident and Health Review: "The companies are now given an opportunity to prove that they can provide cost, service, and actuarial safety, superior to that offered by any other system. . . With the present menace of governmental plans, such a demonstration of the ability of private enterprise to solve the problems confronting it is of especial value."

The Doctor's Album of New Mothers

NO. 24: CAPABLE MISS CLARK

Her *efficiency* startles her doctor. No morning sickness; no cravings for pickles. She works up till the last minute, taking a taxi from office to hospital. And, of course, she has the perfect nursemaid all signed up . . .

So, it's a surprise when, on nurse's first day off, a wild-eyed Miss Clark dashes in with howling infant. "He's got *speckles!*" she gasps.

Miss Clark, who has carved quite a career under that name, startles waiting patients by continuing to use it (though she's an honest-to-goodness "Mrs.").

New mothers, even poised ones like Miss Clark, often get upset when they mistake little external skin irritations for dread diseases.

To prevent these irritations, many doctors recommend frequent dustings with gentle, soothing Johnson's Baby Powder. As you know, irritations occur far less frequently when a baby's skin is well cared for.

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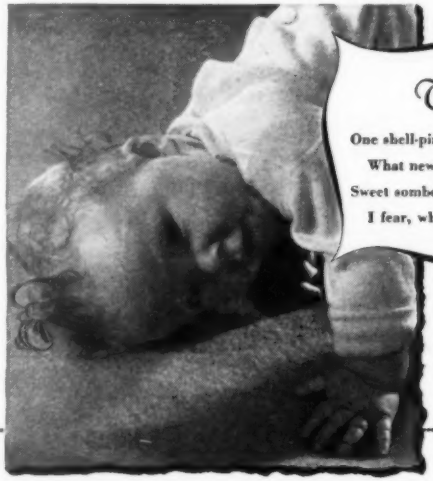

Topsy-Turvy

One shell-pink ear pressed to the ground—
What new distraction have you found?
Sweet somber-eyes, the world's a tangle,
I fear, when viewed from *any* angle . . .

Your youngest patients like vegetables when you prescribe Heinz Baby Foods for them because:

First, vegetables for Heinz Baby Foods are grown where the fertile soil produces the most desirable crops. *Second,* fine, fresh flavors and colors are preserved by processing fruits and vegetables scientifically. *Third,* vitamins and minerals are retained in high degree by these modern cooking and packing methods. *Fourth,* constant checking and testing by the expert food technicians in Heinz Quality Control Department assure uniform quality of all Heinz Baby Foods.

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